Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last Month **Physician** March /Medical Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital Baltimore If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 119-80-4474 61 January 5,1950 China Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location show 1 ☐ Yes 2 No r 28a-f s notified Directo Maryland Montgomery Damascus 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? ò items 23a or ner must be i 10432 Damascus Park Lane USA 20872 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status ed other than "natural", or ite event, the Medical Examiner Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 € If Yes, Give Year or Dates: 2 No altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4 or 5+) 9 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ith and Mental F 27 is marked ot traumatic even Unknown Jin Xia Wii ٩ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) int of Health a t: If item 27 is or other trai Tian Shi Lai/ Husband 10432 Damascus Park Lane, Damascus, Maryland 20872 20b. Place of Disposition (Name of cemeter, crematory or other place)
All Souls
Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) March 16,2011 Germantown, Maryland 21. Signature of Funeral Service Licenses permit. Molesworth-Williams, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland 20872 Part 1. Enter the disease, or complications the shock, or heart failure. List only one cause of caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician counc /Medical Due to (or is a consequence of): Examiner Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to for as a consequence of requires that the death certificate be executed g physician and as the burial-trans resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical attending p IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Vear 5 Other (specify) ate has been signed by the a page 2 should be detached 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ No 1 Tes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 1 🗌 Yes 2 No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 2 No 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) ၉ this within 24 hours after death.

To the Funeral Director: After this completely filled in by the funeral 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28h. Time of 28a. Date of Injury Certification: or Attending 1 Natural 2 Accident (Month, Day Year) Injury Pending investigation M 1 Yes 2 🗆 No 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, determined 4 Homicide building, etc. (Specify) City or Town, State) Hospital Kcertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only onel

31. Date filed (Mon State Registrar

29b. Signature

no title of certifie

5

sophie

wells MD registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Wells

parke

29c. License number

RES-000

600 North Wolfe St, Baltimore, MD, 21287

29d. Date signed (Month, Day, Year)

To the I within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Vear Physician/ March 20 Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Maid 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign **Funeral** 1 1 M 2 □ F Country) Months Director Usual Residence of Decedent or items 23a or 28a-f show 10b. County should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No 10e. Street and Number 10a. Citizen of What Country? Funeral 6 Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 ☑ No Black, White, etc. 1 Never Married 2 Married δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed BIack 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Construction -Machine Operato Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic o traumatic P.MC 19a. Informant's Name/Relationship (Type, Print) Helen 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Grove Cometery 4 ☐ Donation 5 ☐ Other (Specify) Reids Grove, 22. Name and Address of acility Henry Funeral Signature of Funeral Service Licensee shington 23a. Pard 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ 070001disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner mu Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Due to for as a consequence of: Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last the burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death signed by the a d be detached for 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has k completed filled in by the funeral director, page 2 s autopsy performed death? 1 TYes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 7 No Other: ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🔀 Certitying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s 3 Certitying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 29c. License number laws 388 30. Name and address of person who completed cause of death (Item 23a) (Type,,Print) Michre 302 CUII 31. Date filed (Month, Day, Year) 32. Registrar's Signature State MAR 18 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 10503 For State Registrar Certificate of Death 3. Time of Death dent's Name (First, Middle, Last) Date of Death Physician/ 201 9:15 A M te5 Medical 4c. County of Death 4b. City, Town, or Location of Death **Examiner** tomore 8. Date of Birth 9. Birthplace (State or Foreign If Under 24 Hrs. **Funeral** 5 a 0 Pa 1 □ M 2 😿 F Months Director a or 28a-f show be notified at 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland Director 1 🗌 Yes 2 🛰 o indsor move 10f. Zip Code 10g. Citizen of What Country? 10e. Street and N or than "natural", or items 23a or the Medical Examiner must be Funeral USA 10.7 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent 11. Marital Status Armed Forces?
1 ☐ Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 ☐ Yes 2 🕬 No If Yes, Give 3 ₩Widowed 4 □ Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) ruit. Page 1 and 2 should be filed within 72 artment of Health and Mental Hygiene cortant: If item 27 is marked other than 'injury or other traumatic event, the Me College (1-4 or 5+) Elementary/Seconday (0-12) Be Mather's Name (First, Middle Maider 17 Father's Name (First, Middle, Last Informant's Name/Relationship (Type, feet and Number or Rural Route Number Baltimore, Place of Disposition (Name of 20a. Method of Disposition pernit, Page 1 a
Der artment of H
Important: If ite
any injury or oth 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, cremator, Signature of Funeral Service License 23a. Part 1. Ent. th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final eno Carcinua Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Pregnant at time of death signed by the a 2 🗌 No 9 Unknown a I I Inknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has ; page 2 s autopsy performed 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? **Division of Vital** funeral director, Be 26. Place of Death (Check only one) 2 No Hospital: 1 Tes မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After work? 1 🗌 Yes 1 Natural injury 5 Pending To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun Accident Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [only one) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Siller errance 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

			State of Maryland / De	partment of Health and e <i>rtificate of Death</i>		gien2 0 1 1	10504			
			Registrar 1. Decedent's Name (First, Middle, Last)	Fillioate of Boati	2. Date of Dea	ith	3. Time of Death			
	Physicia		John	bt	Month March	29 2011	03 47 PM			
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Dea		4c. County of Death	1			
_			The Johns Hopkins Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthda	Baltimore City If Under 1 Year If Under 24 H	rs. 8. Date of Birtl	h 9. Birth	nplace (State or Foreign			
	Funeral Director		$ \begin{array}{c ccccccccccccccccccccccccccccccccccc$	Months Days Hours Mil		7, Year) Cou 1951 I1	nplace (State or Foreign ntry) 1inois			
			Usual Residence of Decedent				10d. Inside City Limits			
	arylan show	J.	10a. State 10b. County 10c. City, Town or MD Anne Arundel Hanove				1 ☐ Yes 2 No			
	the M	Director	MD Anne Arunde1 Hanove	10f. Zip-Code		10g. Citizen of What Cou	intry?			
	I be filed within 72 hours after death with the Marylan and Hygiene. and Hygiene. ad other than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at		1912 Wamsutta Lane	21076		USA				
	ems 2	Funeral	11. Walital Status	Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pue	(Specify Yes or No- erto Rican, etc.)	14. Race - Amer Black, White				
9	s after	by Fi	1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced Page 7 Dates: 1993	1 ☐ Yes 2 👿 No Specify:		Specify: W	hite			
15-0036	tural'	ted t	15. Decedent's Education 16a. De	cedent's Usual Occupation ive kind of work done during most of w	vorking	16b. Kind of Business/	Industry			
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7	ygien ygien her th: t, the		12 8 S	ystem analyst	lame (First, Middle,	, Maiden Surname)				
land	d be fil ntal H ed otl	Be c	Thomas Francis Abt	I		Ashworth				
چ	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show is marked other than "natural", or items 23a or 28a-f show aumatic event, the Medical Examiner must be notified at	은	19a. Informant's Name/Relationship (Type. Print) 19b. M	ailing Address (Street and Number or	Rural Route Numb	er, City or Town, State, Z	ip Code)			
2	and 2 ealth a n 27 is		Michiyo Abt - wife 1	912 Wamsutta Lane						
Baltimore,			1 Burial 2 Cremation 3 Removal from State	sposition (Name of crematory or other place)	Date	20c. Location - City or	Iown, State			
<u>=</u>	permit. Pages 1 Department of F Important: If ite any injury or ot		4 X Donation 5 Other (Specify) 21. Signatur of Fune Service Licensee	22. Name and Address of Facility	tate Anai	tomy Board	and the same			
g	Depa Impo any i		mald S. Wall Director	655 W. Baltimor		•	21201			
П			23a. Part Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	enter the mode of dying, such as card	liac or respiratory a	rrest,	Approximate Interval Between Onset and Death			
-	Physician		Immediate Cau Final disease or condition a. IN 22 NO	HEMPSOME E			Onset and beauti			
>	/Medical Examiner		resulting in death) Due to (or as a consequence of):	0.7	4					
		ner	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of).							
	cuted d ransit	Examin	cause. Enter Underlying Cause (Disease or injury that initiated events c		<u>-</u>					
Ď,	certificate be executed rding physician and use as the burial-transit		resulting in death) Last Due to (or as a consequence of):							
8760,	cate b	edical	d							
89 ×	certifi nding use a	M/m	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death	3 ☐ Ectopic pregnancy		23d. Date of de	•			
EOX	v requires that the death certifica been signed by the attending pl should be detached for use as	Physician/M	In the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death	5 Other (specify)		Month	Day Year			
J.	law requires that the as been signed by the 2 should be detach	Phy	9 Unknown Part II. Other significant conditions contributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did 1	tobacco use contribute to	o the cause of death?			
gs,	uires the signed ld be o	d by			1 🗆	Yes 2 XNo 3 □ Pi	robably 4 🗌 Unknown			
S	w requ been shou	Completed			24a. Was		utopsy findings available completion of cause of			
2	The law ite has f page 2	Som			perfo 1 ☐ Yes	rmed? death?	s 2 □ No			
/Ita		Be	25. Was case referred to medical examiner?	Other:	Death Check onl o					
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0	ding F th. After funer	tion	1X Natural 5 ☐ Pending (Month, Day Year) Inju 2 ☐ Accident investigation							
Division of Vital Records,	Atten er deal ector: by the	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of injury - At home, farm building, etc. (Specify)	, street, factory, office	28f. Location Cify or Tox	(Street and Number or Fi vn, State)	Rural Route Number,			
ב	ital or urs afte ral Dir lled in	Cer	29a. Certifier 1 K Certifying Physician: To the best of my knowledge, c	eath occurred at the time, date and of	ace, and due to the	cause(s) and manner a	s stated.			
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifica completely filled in by the funeral director.	edical	29a. Certifier (check only one) 1 ★ Certifying Physician: To the best of my knowledge, c (check only one) 2 ★ Medical Examiner: On the basis of examination and/s and manner stated.	or investigation, in my opinion, death o	occurred at the time	, date and place, and du	ue to the cause(s)			
	To the To the Compl	Me	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moni	th, Day, Year)			
			· pet	RES-000		March 29	2011			
			30. Name and address of person who completed cause of death (Item 23a) (T	/pe, Print)	0 North W	olfe St. Baltim	ore, MD, 21287			
	Sta	ite.	31. Date filed (Month, Day, Year) 31. Date filed (Month, Day, Year)			,				
	Regist		31. Date filed (Month, Day, Year) APR 0 4 2011 APR 0 4 2011	acker						

DHMH 17 Rev 1/2001

FULLI E/M

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Day 2011 Year Harry Eugene Allen 2 6:20 A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Westminster Carroll 9. Birthplace (State or Foreign Country) Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth **Funeral** Min 1 XM 2 F Months 343-12-5568 83 1927 Yrs **Director** May Usual Residence of Decedent 10a. State 10b. County the Maryland 10c. City, Town or Location 10d, Inside City Limits notified at Director 28a-f IllFord 1 Tes 2 No Paxton 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? ms 23a or must be r Funeral with t 249 East State St. 60957 USA items ner mu 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) death Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 11. Marital Status ö ģ 1 Never Married 2 Married the Medical Examir Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates Specify: white "natural", Completed 3 Midowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Supervisor marked other permit. Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Loran H. Allen Dora Trotter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pamela R. Powell-daughter 985 Ridge Rd., Finksburg, MD 21048 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4-8-2011 Paxton, Ill 4 ☐ Donation 5 ☐ Other (Specify) Glen Cemetery 21. Signature of Juneral Service Licenses 22. Name and Address of Facility Fletcher Funeral Home 254 E. nonvas 21157 Main St., Westminster, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician; The law requires that the death certificate be P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death signed by the at d be detached for ☐ Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Probably 4 Unknown been si should Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy Yes 2 Be 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 1 Other (Specify House ပ္ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 45PICE 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural injury 5 Pending ☐ Accident Investigation 6 Could not be 3 Suicide
4 Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical E winer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated in the Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one) 29b. Signature and title of 29d. Date signed (Month, Day, Year) 4/3/11

DHMH 17 Rev 7/2009

State

Registrar

30. Name and address of p

Date filed (Month, Day, Year)

APR 0 4 2011

NORONC

Center St., Westminster, MD 21157

completed cause of death (Item 23a) (Type, Print)

555 S.

32. Registrar's ignatur

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 3. Time of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ 2:15pM MARCH 31 ERMER B. ALBRITON Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** BALTIMORE 3855 GREENSPRING AVE. 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🏻 F Months Days Hours ARKANSAS **Director** 93 203-12-2218 Usual Residence of Decedent 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Marken Example. 10b. County 10c. City, Town or Location 10a. State Director BALTIMORE 1 Yes 2 No MD. N/A 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 3855 GREENSPRING AVE. 21211 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Black, White, etc. Armed Forces 1 Yes 2 No þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: BLACK 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) CHILDREN SERVICES -12--7-SOCIAL WORKER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ LVA BREWER HENRY BREWER 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 10 ST. GEORGES RD. BALTIMORE, MARYLAND 21210 JAMES ALBRITON(SON) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial Cremation 3 X Removal from State HIGHLAND PARK CEMETERY 4-8-2011 5 Other HIGHLAND HILLS, OHIO 4 Donatio Specify) IONATHAN D HIBNER Name and Address of Facility REDD FUNERAL SERVICE 21. Signature of 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 er the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between 23a. Part 1 eart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition rement A Pnysician 1-Medical resulting in death) Du to (or as a consequence of) **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-trar Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: s, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 in the past 12 months? Month Day Year Pregnant at time of death ☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed completed filled in by the funeral director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy death? 2 1 No after death.

Director: After this certificate Yes 25. Was case referred to predical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 2 No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred injury Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Sulcide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29d Date signed (Month, Dav. Year) 29b. Signature and title of certifier 29c. License number 2611 DZ UN WE completed cause of death (Item 23a) (Type, Print) 30. Name and address of person wh

State Registrar

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D.

DOW

31. Date filed (Month, Day, Year)

APR 0 4 2011

5901

32. Registrar's Signature

AND)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 4:40 A M Buckingham March 2011 Thelma Corrine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Golden Living Center 8. Date of Birth (Month, Day, Ye Dec 24 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 🗆 M 2 🗶 F Months Hours Maryland Dec. Director 67 220-40-7768 Usual Residence of Decedent ural", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director 1 Yes 2 No Westminster Maryland Carroll 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 21157 U.S.A. 1234 Washington Rd. "natural", or items vithin 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Black, White, etc. Armed Forces Yes 2 XNo þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify: Specify. 3 Divorced White Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) tool mfq. machinist 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be fi of Health and Mental item 27 is marked Ruth Wolfe J. Oscar Buckingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) New Windsor, MD 21776 Peggy Mester-Harris/ sister 10209 Parsonage Lane injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a
Department of H
Important: If ite
any injury or oth Page 1 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/3/2011 Pipe Creek Cemetery nr. Linwood, MD 21. Signature of Fundral Service Licen 22. Name and Address of Facility Hartzler Funeral Home New Windsor, MD 21776 310 Church St. 23a. Part 1. Enter the disease, or complications that caused ne death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine and -transit Cause (Disease or iinjury that initiated events resulting in death) Last burialattending physician Physician/Medical that the death certificate be Box 68760 as the IF FEMALE use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 month 3 Ectopic pregnancy for Pregnant at time of death 5 Other (specify) the Unknown detached Unknown P.O. ρ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I δ Division of Vital Records, Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No has page 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral of 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural Accident (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation
6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier Date signer (Month, Day, Year) 29c. License number 20 nd address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Items 25,28f per me g914 4-4-11 yt. State of Maryland Department of Health and Mental Hygiene 0508 Certificate of Death 1. Decedent's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ elen Bezold Month Year 3 Day 1400 Medical 2011 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Columbia Howard Howard County General 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 □X Months Days Hours Min. Month, Day Year - 20-1922 Director MD 219-01-5115 89 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No MD Baltimore Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21228 USA 1 Rumsford Road, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married þ Yes 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: id Mental Hygiene. marked other than "natural", If Yes, Give Specify: White 3 Nidowed 4 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) <u> Homemaker/Sales Clerk</u> Own Home/ Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elwood Pattison Helen Peters 1 and 2 should by Health and Meitem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6934 Westcott Place Clarksville MD 21029 John C. Bezold/ son 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a Department of h Important: If ite Date cemetery, crematory or other place) any injury or Woodlawn, MD 4 Donation 5 Other (Specify) 4-4-2011 Lorraine Park 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc 4112 Old Columbia Pike Ellicott City MD 21043 400845 23a. Par 1. Enter the disease, o' complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ omplication o disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit The law requires that the death certificate be executed Cause (Disease or iinjury SEMULICIATION WAS BOKED BY MEDICAL EVEN that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Vear Pregnant at time of death Day signed by the a d be detached f Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed After this certificate funeral director, pag 2 1 No Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 X Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending s after death.

I Director: Aft d in by the fur 3/24/2011 4:00 M 1 Yes Accident Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Nu**Rumsficined** te Number, City or Town, State) | Rumsfield Drive Catomsville MD in 24 hour.
Se Funeral Dir.
A filled in bv. 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 only one) 29b. Signature and title of certifier 59005 unershu hr. 1 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) edar Ln. Columbia MD-21044 umera Mujahid 5755 31. Date filed (Month, Day, Year) State Registrar

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10509 State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year 4=41 AM Physician/ HEDWIG BUNDA March 3 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE N/A LEVINDALE
5. Social Security Number 9. Birthplace (State or Foreign Country) ROMANIA 8. Date of Birth (Month, Day, Year) 06/17/1924 7. Age (In yrs. last birthday) 6. Sex **Funeral** Hours Months 1 🗆 M 2 🔽 F 86 NONE Director Usual Residence of Deceder "natural", or items 23a or 28a-f show idical Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State within 72 hours after death with the Maryland Director **BALT IMORE** 1 X Yes 2 No N/A MD 10f. Zip Code 10g, Citizen of What Country? 10e, Street and Number Funeral **ISRAEL** 21215 2434 W. BELVEDERE AVENUE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2XXNo Specify: permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ACCOUNTING ACCOUNTANT Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ **ZICHERMAN** BASYA AARON ZVI WEINSTEIN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6605 GREENSPRING AVENUE, BALTIMORE, MD 21209 GEORGE MITTELMAN/SON Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CHEVRA AHAVAS CHESED 04/01/2011 RANDALLSTOWN, MD 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licenses PIKESVILLE, MD 21208 8900 REISTERSTOWN ROAD, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final DISEASE -¢hysician/ CORONARY ARTERY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events are little death). Due to (or as a consequence of) Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery Physician/ 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Tes 2 No 3 Probably 4 Unknown DEMENTIA Division of Vital Records, Completed 1 24b. Were autopsy findings available prior to completion of cause of 24a. Was an HYPERTENSION autops\ perform Yes 2 N 1 ☐ Yes 2 ☐ No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 IDOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending work 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the causes 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier D0063327 Darow H. WORDEHINEST 31 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WOLDEHIWOT, MA 2434 WI BELVEDERE AVE, BALTIMORE, MD 21215 GIZAW 32. Registrar's Signature 31, Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number, Town, or Location of Deat 4c. County of Death **Examiner** N/A Hmore 9. Birthplace (State or Foreign Country)
Maryland Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 8 De e of Birth **Funeral** Min 1 □ M 2 🔀 F 08/08/ 1952 214-64-5104 Director 58 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ¹y Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1637 N. Gilmore St 21217 .S.A 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 1 Never Married 2 Married þ 1 Yes 2 X No Specify and Mental Hygiene. is marked other than "natural", Specify: Black Completed 3 Widowed 4 Divorced permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Flementary/Seconday (0-12) 12th Grade College (1-4 or 5+) Day Care Provider unk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Emick Campher <u>Anna Green</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5813 Glenkirk Ct., Clarence Kendall Jr(son) Baltimore, MD 21239 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) king Mem. Park 04/07/11 Baltimore, MD 22. Name and Address of Facility Joseph H. Brown Jr. 2140 N. Fulton Ave., 21. Signature of Funeral Service Lic 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events aderate sician and burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Live Birth 2 Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death the 9 Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Tes 2 No 3 Probably 4 Unknown cate has been siç ; page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2 🗌 No ER/Outpatient 3 DOA မ 1 Inpatient in 24 hours after death.

he Funeral Director; After this inleted filled in by the funeral di 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie tigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Medical Examiner: On the basis of examination and/or inve 3 Certifying Nurse Practioner: To the best of my knowledge, within 2 To the F only one death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signat 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltonia M 31. Date filed (Month, Day, Year) APR 0 4 2011 32. Registrar's Signature State Registrar

11-02107	
Brandon Carter	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Manyland / Department of Health and Mental Hygiene

nanuc	n Carter		1- For State Registrar	tate of Maryland		rtificate of		iu ivierii		Reg. No.	2011	10511
Medic	Physici al Exami	an/	1. Decedent's Name (First, Midd						2. Date of De Month March 17	ath		3. Time of Death 2137 hrs
ļiouio	ai Exami		Brandon Kelvin 4a. Facility Name (if not instituti)	4	b. City, Town, o	or Location of			. County of Death	
			University Hospital S		o (la usa l	ant histheless	Baltimore If Under 1 Ye	ear If Under	24Hre 8 Date of B	irth (AAAA/I	N,	A
	Funeral Director		5. Social Security Number 215-98-5233 Usual Residence of Decedent	6. Sex 7. Ag	29	ast birthday) Yrs.	Months Da		Min. Jan. 1	1500	Foreign	
	' any		10a. State 10b. County	,	10c. City	, Town or Location	on					10d. Inside City Limits
	Maryland 28a-f show d at once.	tor	MD	N/A	Balt	imore	10f. Zip Code			10a Citiz	zen of What Coun	1 Yes 2 No
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shoinjury or other traumatic event, the Medical Examiner must be notified at once.	Director	10e. Street and Number 5202 Cuthbert	Avenue				1215		rog. Oiliz	USA	
	th with tems 23 at be no	Funeral	11. Magital Status	12. Was Decedent Armed Forces	?_/	.S. 13. Was	Decedent of H	lispanic Origi an, Mexican,	in? (Specity Yes or N Puerto Rican, etc.)	lo-	14. Race - Americ White, etc.	an Indian, Black,
	ifter dez Il", or i	by Fu		1 Yes 2 Vorced If Yes, Give Year or Dates:	₩ No	1	Yes 2 N	lo s <i>pecify:</i>			Specify: Blac	k
	hours a 'natura Exami		15. Decedent's Education (Specific Elementary/Secondary (0-12	ecify only highest grade cor			s Usual Occup st of working lif		ind of work done use retired)	16b. K	(ind of Business/Ir	ndustry
036	ithin 72 me. r than fedical	Completed	Elementary/Secondary (0-12)	2 Years	•		Car De	aler		Se.	lf-Emplo	yed
MD 21215-0036	filed wall Hygie ed othe	Be Co	17. Father's Name (First, Middle Curt Carter	, Last)					s Name (First, Middle ly Simon	, Maiden	Surname)	
212	Menta Mark mark c even	9 9	19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailing	Address (Stre		ber or Rural Route Nu	ımber, Cit	ity or Town, State,	Zip Code)
Ω	d 2 sho Ith and n 27 is		Beverly Jackso	n - Mother			<u> </u>		et Baltim			
ē	s l an of Heal If iten her fra		20a. Method of Disposition 1 Burial 2 Crematic	n 3 Removal from St	ate	Place of Disposition of the properties of the pr	er place)		Date		Location - City or 1	·
Baltimore	t. Pagrtment rtant:		4 Donation 5 Other S 21. Signar re of Funeral Septing	Specify:	Wo	odlawn	Cemeter ame and Addre	- 1	3/25/2011		odlawn,	
Bal	Depar Impo injur		-X ~//	w					Chatman-Hai Road Baltimon			
	hysician Madicul		23d. Part I. Enter the disease, of failure. List only one cause	e on each line.					rdiac or respiratory a	rrest, sho	ock, or heart	Approximate Interval Between Onset and Death
	xaminer	Ì	Immediate Cause (Final diseas or condition resulting in death)	e a. Gunshot Wound Due to (or as a cons			d Left Butto	ock (1)				Deau
		<u>.</u>	Sequentially list conditions, if any, leading to immediate	b	edilence o	f):						
		Medical Examiner	cause. Enter underlying Cause (Disease or injury that initiated	C								
	cuted ind transit	EX	events resulting in death) Last	d								
90.	te be executed sysician and burial - transit	edica	UNPENDED	AMENDED						Lac		
Box 6876	certificat inding ph		IF FEMALE: 23b, Was decedent pregnant in past 12 months?	the 23c. If yes, outcome the 1 Live birth 4 Pregnant at		2 Fet	al death 3 er (Specify)	Ectopic	pregnancy	230	d. Date of delivery Month D	ay Year
ĝ	ne death the att	hysi		1known 9 Unknown	J- 144 -			niver in Dor	- 1 23e Did	tobacco	use contribute to t	he cause of death?
P.0	The law requires that the death cate has been signed by the atte page 2 should be detached for u	þ	Part il. Other significant condi	uons contributing to deal	in but not r	esulting in the di	idenying cause	giverim rai				ably 4 Unknown
of Vital Records,	w requires t s been sign should be o	Completed								opsy	prior to co	opsy findings available ompletion of cause of
Reco	The laricate hapage 2	L Som							1 ✓ Yes	formed?	death? o 1 ✓ Yes	s 2 No
<u> </u>	ician: The s certificate irector, page	å	25. Was case referred to medic examiner?	W1 W 1	ent 2 🗸	ER/Outpatient		1Other -	Check only one) Nursing Home 5	Reside	nce 6 Other:	
		7: T	1 ✓ Yes 2 No 27. Manner of Death	28a. Date of Inju	ury	28b. Time of In		jury at Work?	28d. Describe	how inju		
Division		catic	2 Accident Inve	estigation 28e Place of Ir		ome, farm, stree	t, factory, office	Yes 2		(Street a	ind Number or Rur	al Route Number, City
ō.	ospital or At hours after d uneral Direct y filled in by	Certification:	4 Momicide	ermined (Specify) Fa	st Food				or Town, 2738 Penns	State) ylvania /	Avenue, Baltimo	ore, MD
	To the Hospital or Atten within 24 hours after death To the Funeral Director: completely filled in by the	Medical (29a. Certifier 1 Certifying I Cone) 2 Medical Ex	Physician: To the best of maminer: On the basis of exa and manner stated.	ny knowled amination a	lge, death occurr and/or investigati	ed at the time, on, in my opinio	date and place on, death occ	ce, and due to the car curred at the time, dat	use(s) and e and pla	d manner as state ace, and due to the	d. e cause(s)
	E BES	Me	29b. Signature and title of certif	ier				nse number			Date signed (Mon	th, Day, Year)
n	LV		30. Name and address of perso	who completed cause of a	death (Item	1 23a)		C.M.E.		IVIAI	ch 18, 2011	
-)			ant Medical Examine			t, Baltimore	, MD 2120	01			
	S Regis	tate trar	31. Date filed (Month, Day, Year APR 0.4.2011	32. Registra	ar's Signati	ure						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death Decedent's Name (First, Middle, Last) Physician/ ammack 20 M Carson march 2 &M Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death, **Examiner** polal Howard Lounth Genera olun 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, Funeral Months Days 1 **≥** M 2 □ F 8 Jan Director 424-28-351 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 🎖 Yes 2 🗌 No MD 10e. Street and Number 10g. Citizen of What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 🗌 No Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Black Year or Dates 16a. Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 1 0 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) lle daughter CAMMON CAC 20b. Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, Stay 20a. Method of Disposition ☐ Burial 2 Cremation 3 Removal from State 4 X Donation 5 ☐ Other (Specify) PA 18434 22. Name and Address of Facility 21. Signature of Emperal Service 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line. nter the diseas or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratorylarrest Approximate Interval Between Onset and Death Milloma Immediate Cause (Final disease or condition resulting in death) Physician/ for owner Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of). Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 | Haknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? Hospital: 1 🔲 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA မ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural 5 Pending 1 \sum Yes n 24 hours after death.

e Funeral Director: A pleted filled in by the fu Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check 3 🗆 within 2 To the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Registrar DHMH 17 Rev 7/2009

State

29b. Signature and title of certific

31. Date filed (Month, Day, Year)

Sabapath

APR 0 4 2011

Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar's Signature

6

arcl

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death (ARTNAIL: Month MAR 8:35 PM Physician/ RONALD 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PROSPECT BLUD APTZOZ FREDERICK FREDERICK If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-68-8602 1 M 2 D F Days JAN 14, Year) 958 Country) MS 53 Director permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-6-100ce. 10d. Inside City Limits 10a. State 10c. City. Town or Location Director FREDERICR FREDERICK 1√Yes 2 □ No MD. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 350 A PROSPECT BLUP APT 202 21701 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 ☐ No Specify: Specify: BLACK 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) OF FREDERIUR College (1-4 or 5+) Elementary/Seconday (0-12) SANITA TION Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) CARTNAIL BOWIE LARRY BETTY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2:701 19a. Informant's Name/Relationship (Type, Print) 350 A PROSPECT BLVD APT 202 FREDERICK MO CARTNAIL (WIFE) 20b. Place of Disposition (Name of CA .CM - cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State DAMASCUS, MB. PLEASANT GROVE UM. MAR 31, 2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROWNS FUNCEST I tomE 21. Signature of Funeral Service Ligensee Juny L. olli SOUTH ST FREDERICK MO 21101 110 WCST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of lying, such as cardiac or respiratory arrest, shock, or hart failure. List only one cause on each line. Opset and Death
MONTHS - EARS Immediate Cause (Final HEPATOCELLULAR Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 4 ☐ Pregnant a 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by HEPATITIS 1 Yes 2 No 3 Probably 4 Unknown RELATED CACHEXIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Nursing Home Hospital: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Dea h 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? Investigation Accident Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined within 24 hours a Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Johnson & Frederick MB 21702 TAIMUR MD 46B Thomas 31. Date filed (Month, Day, Year)

Registrar

			Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
		4	State of Maryland / Department of Health and Mental Hygiene
		. 4	Registrar Certificate of Death Reg. Not. U 1 1 1
	Physicia Medic		1. Dependent's Name (First, Middle, Last) Dames Edward Dowtin, Jr. 2. Date of Death Month Ago, 2011 5:00 PM
	Examin	er	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 8altimore 4c. County of Death 8altimore
	Funeral		5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Months Days Hours Min. (Month Days)
	Director	1 h	Usual Residence of Decedent
	//aryland 8a-f sho tified at	rector	10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 \(\text{Yes 2 } \) Avo
	72 hours after death with the Maryland n "natural", or items 23a or 28a-f sho fledical Examiner must be notified at	Funeral Director	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21206 USA
	death v r items iner mu		11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc.
0036	urs after :ural", o al Exami	ted by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates. 1 Yes 2 No Specify: Specify: Specify:
215-(n 72 hol s. an "nat Medica	Completed	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) College (1-4 or 5+) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
21	within /giene. ner thar t, the N		Joth Supervising Chief LIVIDC
Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Department of Heath and Mental Hygiene. Important: I fire Z7 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be	Tames E. Dowtin, Sr. 18. Mother's Name (First, Middle, Last) Narie Philips
Mary	2 should lith and Me 27 is marl traumati		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donna Dowtin (Ex Wife) 2805 Lake Avenue, Balto, MD 21213
Baltimore,	permit. Page 1 and 2 s Department of Health Important: If item 27 any injury or other tra		20a. Method of Disposition 20b. Place of Disposition (Name of Disposition - City or Town, State Competent of the place)
altim	mit. Pag partmen portant: r injury	1	21. Signature of Funeral Service Licensee / 22. Vine and Atdress OF a Breene Funeral Service &
m	Depar Impo any ir		Varigh C. Mille 5151 Batto. Nat'l Pike (21229)
· ~ •	h, sician/		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition.
	Medical Examiner		disease or condition resulting in death) a. Due to (or a a consequence of):
		iner	Sequentially list conditions, b. If any, leading to immediate cause. Enter Underlying
198	oe executed ician and ourial-transit	Examiner	Cause (Disease or lirijury that initiated events c. resulting in death) Last Due to (or as a consequence of):
_	ate be e ohysiciai the buri	dical	d
Box 68760	certifica ending p use as	an/Me	IF FEMALE: 23b. Was decedent pregnant 1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery
. Bo	ne death / the attu ched for	Physician/Medio	in the past 12 months? 1 Yes 2 No 9 Unknown
. P.O.	requires that the death certificate to been signed by the attending phys should be detached for use as the I	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1
rds	equire	eted	24a, Was an 24b. Were autopsy findings available
3eco	he law interhas to	Completed	autopsy performed? 1 Yes 2 No 1 Yes 2 No 1 Yes 2 No
la	sian: T ertifice ctor, p	Be C	25. Was case referred to medical 26. Place of Death (Check only one)
Ę	Physic this ce al dire	은	Hospital: 1
o uc	nding Fath. r: After re funer	icate	1 Natural 5 ☐ Pending (Month, Day, Year) Injury work? 2 ☐ AccidentInvestigation M 1 ☐ Yes 2 No
Division of Vital Records,	I or Atte after de Directo	Certificate:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)
	To the Hospital or Attending Physician: The law requires that the death certificate I within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the I completed filled in by the funeral director, page 2 should be detached for use as the I	Medical	29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
	To the within ? To the comple	Ž	only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
			Michelle Funer Clark R162370 04/01/11
	8		30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 S. Grewe St. Sqc16, Balt more, MD. 21201
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature
	Registr	alî	APR 0 4 2011 Prome A frage

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Davidge Doris 7:02 A M March 201 . Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner leason's 9, Birthplace (State or Foreign al 6. Sex 1 □ M 2 🛱 F If Linder 8 Date of Birth **Funeral** Month Day Director 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director Bal 1 Fes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21229 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) within 72 hours after death Was ecedent Ever in U.S 14. Race - American Indian. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 NWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired)

Sales person 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 10 event, Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle, Maiden Surname Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ၉ Ernest 19a. Informant's Name/Relationship (Type, Print) Route Number, City or Town, State, Zip Code) 19b. Mailing Address (Street and Number or Rural M 21229 ploria 20b. Place of Disposition (Name of Cemetery, cremator, br other 20a. Method of Disposition Date 1 Burial 2 Cremation 3 Removal from State 6-2010 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Cardiovascular Diselse Atheroscierotic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to innectate cause. Enter Underlying Examiner Dije to jor as a consequence of as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of): attending physiciar Physician/Medical certificate be Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 Yes 2 No for Pregnant at time of death To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ Hospital or Attending Physician: The law requires.
 Hours after death.
 Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number MS Rajapame M.D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
N-S. Ryapa KR (M.D. 2835 Sm Smith N-5-703 Baltimore, MD 21200, N.S. Rajapa KSE M.D 31. Date filed (Month, Day, Year) State Registrar

X DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. Ne-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 5-41 A TEK MARCH Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner 13005 Harford Rd Baltimore Hydes If Under 1 Year If Under 24 Hrs. 8. Date of Birth Date of by Month, Day, Ye 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Days 217-38-0082 1**X** M 2 □ F Hours Min. Maryland Director 193 Usual Residence of Decedent 28a-f shov 10b. County rral", or items 23a or 28a-f sho Examiner must be notified at 10a, State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 Yes 2X No Baltimore Hydes MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21082 13005 Harford Rd. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. by 1 Never Married 2X Married "natural", or Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed er than "natur, the Medical B 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) d Mental Hygiene. marked other tha State of Maryland state park maintenance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 7 is marked o ည Catherine Hurlock William Henery Dufour 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13005 Harford Rd; Hydes, Maryland 21082 19a. Informant's Name/Relationship (Type, Print) partment of Health a portant: If item 27 is rinjury or other trau Evelyn S. Dufour - wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1
Department of Important: If it any injury or o once. cemetery, crematory or other place) ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 22 Name and Address of Facility State Anatomy Board Renal Service Licensee 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, on heart failure. List only one cause on each lin Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that juitted exercises) Examine Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed burial-fransi that initiated events resulting in death) Last Due to (or as a consequence of): nding physician Physician/Medical Division of Vital Records, P.O. Box 68760 use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Month Day Pregnant at time of death Other (specify) been signed by the sahould be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No cate has page 2 s autopsy perfor funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Hospital: Other: မ 1 Yes 2 . No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred injury Natural 5 Pending 2 🗌 No Investigation Accident within 24 hours after deat

To the Funeral Director.

completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatur and title of certifier 29d. Date sigged (Month, Day, Year) ပ 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 9 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ William Stanley Davidson 03729/2011 10:55ta Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Hospice Center Towson If Under 1 Year | If Under 24 Hrs Months | Davs | Hours | Min. . Age (In yrs. last birthday) Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-42-6983 02720 / 1945 1 💢 M 2 🗆 F Months Country) **Director** MD Usual Residence of Decedent 28a-f shov iral", or items 23a or 28a-f sho Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Cockeysville 1 Yes 2X No MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12325 Falls Road 21030 USA 12. Was Decedent Ever in U.S. Agned Forces? 12. Yes 2 No If Yes, Give Jan 63 – 66 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Ś Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White "natural", 3 Widowed 4 Divorced Completed or other traumatic event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Dock Worker Longshoreman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Unavailable Robert Davidson ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ..oft. Page 1 and 2 should be should Colleen C. Davidson Wife 12325 Falls Rd Cockeysville MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial X Cremation 3 Removal from State At Tantic Crem 03/31/11 Glen Burnie MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licens 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Pat / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ GASTRIC disease or condition METASTATIC Medical resulting in death) ue to (or as a consequence of) **Examiner** Sequentially list conditions, If any, leading to him reclate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consecuence of) physician and the burial-transit death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 by the a lending partached for use as: IF FEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Box (3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death 9 Unknown 9 Unknown P.O. signed to det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of deatly? Completed by Avenin 3 Probably 4 Unknown Records, 1 Yes 2 No peen CEREBROVASCULAR ACCIDENT 2008 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has performed HYPERTENSION 2 No 2 1 No 1 Yes of Vital To the Hospital or Attending Physician: 25. Was case referred to predical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 other (Spec HOSPICO 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division death. 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: /
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific and address of person who completed cause of death (Item 23a) (Type, Print) 32. State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ ERCOLE JOHN SR. 50 2011 MATCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** COCKEYSVILLE BALTIMORE MARYLAND MASONIC HOME Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) Funeral 1 M 2 🗆 F Hours Min. Month, Day, 8 Director Vrs Usual Residence of Decedent show and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-f shov ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No ARKVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8800 21234 U. 5A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Examiner Was Decedent Ever in U.S.

Armed Forces?

1 △ Yes 2 □ No W W II

If Yes, Give

Year or Dates. Black. White, etc. 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) INTERNAL REVENUE Elementary/Seconday (0-12) College (1-4 or 5+) I.RS. 12 SCRVICC other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ ERCOLE Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rd 20020 ORK ARKTON permit. Page 1 and 2 Department of Healti Important: If item 2; any injury or other t Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State BAHIMORE, 4 ☐ Donation 5 ☐ Other (Specify) April 4,2011 21. Signature of F negal Service Libers 22. Name and Address of Facility ZANNINO oscol lin e, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, it only one cause on each line. Part 1. Enter the disea shock, or heart failure Approximate Interval Between Immediate Cause (Final Onset and Death End Stage Pnysician Done disease or con Pin resulting in dea f) Medical Examiner Bod-o Vuscalar Sequentially list conditions, if any, leading to immediate Examiner cause. Enter Underlying Cause (Disease or iinjury that initiated events attending physician and for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year ate has been signed by the page 2 should be detached Unknown or Attending Physician: The law requires that the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💢 Unknown Division of Vital Record 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X N within 24 hours after death.

To the Funeral Director: After this certificate 2 **N**o 1 🗌 Yes funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) Other: 1 🗌 Yes 2 No 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No completed filled in by the Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3-31-11 wilsom 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 8 ROBERT LIBERTO 350 ST Balto 31. Date filed (Month, Day, Year) State **APR 04** Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Physician/ Month THOMAS . HERMAN . EVERETT 6:42AM Medical 30th 20 4a. Facility Name (if not institution, give street and number, Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Hospital Harbor Baltimore Sex 1 M M 2 D F If Under 1 Year If Under 24 Hrs. 8 Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 217-58-1230 Months Hours Min. 09722 19952 MD Director Usual Residence of Decedent 28a-f shov 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director MD Baltimore Baltimore 1 XYes 2 No 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? Funeral items 23a 11 West Clement St. 21230 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) hours after death 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc.
White 5 1X Never Married 2 ☐ Married ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene, is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) Custodian Church Be Page 1 and 2 should be filed ment of Health and Mental Hygant: If item 27 is marked oth 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Unavailable Faith Helferstay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
116 Haile Ave Brooklyn Park MD 21225 Michael E Carr Auth Agent other 20a. Method of Disposition
1 □ Burial 2 □ Cremation 3 □ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date permit. Page 1 Department of I Important: If it 0 Atlantic Crem 04/01/11 Glen Burnie MD injuny 4 Donation 5 Other (Specify) . Signature of Funeral Service License 22. Name and Address of Facility Simplicity Crem & Fun Serv ThomasAllenPA 7090 Ridge Rd Hanover MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Disease Immediate Cause (Final obstructive Pulmonary Physician/ Chronic disease or condition resulting in death) nore than 10/1 Medical Due to (or as a consequence of): Examiner pati c He Ence month Secreptially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (of as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-transi Hepato rena. and that initiated events Due to (dr as a consequence of): resulting in death) Last physician more than Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death 5 Other (specify) signed by the a 9 | Ilnknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Mepatitis 1 X Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe certificate l 1 Yes 2 No completed filled in by the funeral director, 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 X No ၉ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of After t Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number MD. Res oo1 March. 30th, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21225 3001 Baltimore. South Hanover Street

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) A PR 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 2:00 DM Clinton 104 2011 OL Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE GENESIS RANDALLSTOWN RANDALLSTOWN 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours MARYLAND 214-72-75 6 **Director** 8/21/1945 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City. Town or Location Director 1 ☐ Yes 2X No BALTIMORE MD RANDALLSTOWN 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 9109 LIBERTY ROAD 21133 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify. Specify: WHITE Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) N/A College (1-4 or 5+) N/A item 27 is marked other other traumatic event, i 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) bef UNAVAILABLE CLINTON FLOYD, SR. permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BEVERLY MARTEL/GUARDIAN P.O. Box 153 Fredericksburg, PA 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State MORELAND MEM. PARK 4/5/2011 HILLENDALE, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility THE JOHNSON FUNERAL HOME, MQ1139 Tal 8521 LOCH RAVEN BLVD. TOWSON, MD 23, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed burial-transi and Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No 9 🗌 Unknown P.O. 1 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records. 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No Yes Division of Vital Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 44 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending 2 🗆 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) 24 hours Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the only one) 29b. Signature and title of certifier 006979 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Arnbout 9109 Liberty Road Baltimore, MD

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Goodman Day 3 Physician/ PM 12 Sandra Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** County Baltimore Multi-Medical Genesis Center lowson Age (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 8. Date of Birth Sex **Funeral** Month, Day, Ye Hours 1 🗆 M 2 🗹 i **Director** t. If item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must hamarish and the material of the m 10b. County 10d. Inside City Limits Funeral Director 1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 11. Marital Status 14. Race - American Indian Black, White etc Completed by 1 Never Married 2 Married 1 ☐ Yes If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: DIA 3 Divorced 4 Divorced Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) Be မ Baltimore, 1 Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Stage Physician/ IV Cancer disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director After this certificate has been sinced to the Funeral Director After this certificate has been sinced to the funeral Director After this certificate has been sinced to the funeral Director After this certificate that the second to the funeral Director After this certificate that the second to the funeral Director After this certificate that the second to the funeral Director After this certificate that the second to the funeral Director After this certificate that the second to signed by the attending physician and defeached for use as the burial-transit insufficie Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 🗶 No Year Pregnant at time of death 1 Yes 2 2 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 X Yes 2 No 3 Probably 4 Unknown Respirator Certificate: To Be Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 🗷 Nursing Home 5 🗌 Residence 6 🗋 Other (Specify, 2 🗷 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 X Natural 5 Pending 1 🗌 Yes 2 🗎 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29d. Date signed (Month, Day, Year) 4/4/2011 D71493 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) york Rd. Bowson Bo 20191 7700 Farah 31. Date filed (Month, Day, Year) Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ <u> 23</u> 2ŎĨĨ 0844 James Ervin Green Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 2427 Calverton Heights Avenue Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** 7. Age (In yrs. last birthday) Days June 27, 1947 1 M 2 - F Hours Min. South Carolina 63 Director 247-86-4948 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 2427 Calverton Heights Avenue USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 12 No Specify. Specify: Black 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Construction 3rd Grade Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ethel Mae Webb James Green 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2427 Calverton Heights Avenue Baltimore, MD. 21216 Jimmie Green - Brother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 M Burial 2 Cremation 3 Removal from State Glen Burnie, Maryland 3/29/2011 4 Donation 5 Other (Specify) Cedar Hill Cemetery ^{22. Name and Address of Facility} Chatman Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 21. Signature of Funeral Service Licensee recos a 23a. Part . Enter the / sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Due to (or la conseque ce) f): disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence or) Examin sician and burial-transit Cause (Disease or iinjury that initiated events that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 After this certificate! 2 🗆 No 1 Tes Hospital or Attending Physician: 25. Was case referred to medical director. 26. Place of Death (Check only one) æ Hospital: Other: 1 ☐ Yes 2 ☐ No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending s after death.

I Director: Aff 1 Tes 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \square Homicide determined within 24 hours aff

To the Funeral Di

completed filled in Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

APR 0 4 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

of Vital

Division

Registrar's Signature

reene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 30 Physician/ March 2011 3:00 Elizabeth Louise Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Columbia 10601 Highbeam Court If Under 1 Year | If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🔀 Months Hours Country) 02/28/1928 83 Iowa Director 549-26-3600 Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10d. Inside City Limits and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10a. State Funeral Director Columbia 1 Yes 2 No MD Howard 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21044 United States 10601 Highbeam Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give Completed by Saltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical J 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ Gladys Osborn Clarence Thomas Way 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Highbeam Court T. Gauert -Columbia, MD Son Roger 10601 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🗆 Burial 2 🗀 Cremation 3 🔀 Removal from State 04/11/2011 4 ☐ Donation 5 ☐ Other (Specify) Missouri Vets. Cem. Higginsville, MO 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc 21. Signature of Funeral Service Licenses Collis-4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Yulmonan disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examine Due to (or as a consequence of) if any, leaving to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending howerien and been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month Year Pregnant at time of death Day 5 Other (specify) 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 K Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page 2 performed? death? 1 ☐ Yes 2 📈 No 25. Was case referred to medical 26. Place of Death (Check only one) completed filled in by the funeral director, Be examiner? Hospital Other: 2 X No Certificate: To 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 A Residence 6 Other (Specify) 28c. Injury at work? 27. Manner of Death 28a. Date of injury 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) injury Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) Suite 104 5018 Dorsey Hall Drive

DHMH 17 Rev 7/2009

Registrar

11-02447 Gary E. Geisk	
Physi Medical Exar	
Funera Directo	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Medical Examiner	UNPENDE	d.	AMENDED										
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Q			Southall, MD	Assistant Mo	edical Exa		iliPen	ııı ətree	et, Baltim	ore, MD	21201			
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 1:11:00 300 3 201 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 101151 BLL 11050 CRATE Cano If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number Age (In yrs. last birthday) **Funeral** (Month, Day, une 23 1**X** M 2 □ F Months Days Director 219-30-0798 Maryland <u>June</u> Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10c. City, Town or Location 10b, County 10d. Inside City Limits 10a. State Director 1 ☐ Yes 2 🎽 No Baltimore Randallstown Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 3801 Schnaper Drive 21133 USA Health and Mental Hygiene. tem 27 is marked other than "natural", or items filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒No
If Yes, Give
Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married <u>\$</u> Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: Black 3 Divorced Completed 16b. Kind of Business Industry Kennedy Kreiger Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Institute 11th grade <u>Maintenance Supervisor</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Beatrice Crowley Frances B. Hill. 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Schnaper Drive #113 Randallstown, MD 21133 Virginia M. Hill/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State injury o 4 Donation 5 Other (Specify) Woodlawn, MD 4-1-2011 Woodlawn Cemetery 22. Name and Address of Facility Chatman-Harris Funeral Home Signature of uneral Service Licens 5240 Reisterstown Road Baltimore, MD 21215 23a. Part i. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Medical **Examiner** 0 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or iinjury that initiated events law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the buria Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed I Completed by 1 🗌 Yes 2 🗌 No 3 🗎 Probably 4 🗹 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? page the Hospital or Attending Physician: The 2 1 No the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 Yes 2 No ဂ္ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 5 Pending To the Hospital or Attending within 24 hours after death.
To the Funeral Director: Afte completed filled in by the fun Natural Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practionery to the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number \$5385 29b. Signature and title of 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) QUEL 64 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 12:36 AM Evelvn Geneva Havward Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Saint ames Hospita Itimore. 7. Åge (In yrs. last birthday) 92 If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 579-18-4356 1 □ M 2 🗓 F Hours Min. Months 10/28/1918 Yrs Marvland Director Usual Residence of Decedent or 28a-f show notified at 10b. County 10a. State within 72 hours after death with the Maryland Director City, Town or Location Halethorpe 10d. Inside City Limits Maryland Baltimore 1 ☐ Yes 2√1√2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a or ner must be n Funeral 21227 5506 Highridge Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, the Medical Examiner Armed Force Black, White, etc. ŏ þ 1 Never Married 2 Married 2 💢 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes XX No Specify: Specify: White 3XXWidowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker of Health and Mental Hygie of Health and Mental Hygie fitem 27 is marked other rother traumatic event, the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lulu Mae Beall Calvin Walker Jesse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 6602 Rapid Water Way /303,Glen Burnie,Maryland,21060 Elaine G. HaywarDaughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Memorial 4/4/2011 Elkridge, Maryland 22. Name and Address of Facility Gary L. Kaufman Funeral Home, Inc Signature of Funeral Service License 7250Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Opset and Death Immediate Cause (Final atherosclevotic Cardiovascular Disease Physician disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a nsequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav Pregnant at time of death signed by the a d be detached for 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown within 24 hours after death.

To the Funeral Director; After this certificate has been si completed filled in by the funeral director, page 2 should I Were autopsy findings available prior to completion of cause of 24a. Was an performed? Yes 2 No death? 1 Yes 2 A 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 E No မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. . Signature and title of certifier 29d. Date signed (Month, Day, Year) March 29, 2011. WI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ave, Baltimore MD 21229 900 S Caton Mason 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 4 2011 Registrar

DHMH 17 Rev 7/2009

award,

The law requires that the death certificate be executed Division or Vital Records, P.O. Box 68760, Physician:

Saltimore, Maryland 21215-0036

Hospital or Attending within 24 hours after death.

To the Funeral Director completely filled in by

State Registrar

4 Homicide

29b. Signature and title of certifier

29a. Certifier

29c. License number 20061199

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

6701 N Charles St Suite 4105, Touson MO 21204

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Rea. No Decedent's Name (First_Middle, Last) 2 Date of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randal wholx Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) Funeral 1 🗆 M 2 🔀 F Hours (Month, Day, Year)
March 19,1949 North Carolina Director 218-48-2395 61 Usual Residence of Decedent show 10b. County 10c. City. Town or Location 10d. Inside City Limits death with the Maryland "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director 1 Yes 2 No N/A Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21205 1005 N. Gay Street Apt. 102 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 be filed within 72 hours after 1 Yes 2 No Specify Specify: Black 3 Midowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Self Employed 11th grade Private Duty Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eddie Lee Taylor Beatrice Elizabeth Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Canty/ Sister 3601 Courtleigh Drive Randallstown, MD 21133 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖾 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crownsville,MD Crownsville Vet. Cemetery Signature of Foneral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, MD 21215 Part 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Ust only one cause on each line. 23a. Part 1. Enter the disease, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician ue to (or 's a consequence of) Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner Due to for sels consequence on Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death 2 🔊 No ate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy ormed? irector: After this certificate I 1 Yes 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital 2 📈 No Other: ျ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 🗴 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

Registrar

Date filed (Month, Dav. Year)

APR 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Lucinda Jackson Medical 4a. Facility Name (if not institution, give-street and number 4c. County of Death **Examiner** Taryland ZULTIMOTE N/A 9. Birthplace (State or Foreign 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth . Age (In yrs. last birthday) Funeral Month, Baz Year 1964 Country)Florida Min. 1 □ M 2 🗹 F Director 217-84-0089 46 Yrs. Usual Residence of Decedent f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Baltimore N/A MD Baltimore, Maryland 21215-0036 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21201 1102 Druid Hill Avenue Apt. 1410 12. Was Decedent Ever in U.S. Armed Forces? / 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Specify. Specify: Black 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11th Grade Unemployed N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Charles B. Jackson Inez Anderson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 2501 Violet Avenue Apt. 404N Baltimore, MD. 21215 <u>Inez Jackson</u> - Mother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 M Burial 2 Cremation 3 Removal from State Zion Cemetery 3/26/2011 Lansdowne, Maryland Mt. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Signature of Funeral Service Licenses 22. Name and Address of Facility Chatman Harris Funeral Houe 5240 Reisterstown Road Baltimore, Maryland 27215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failurer List only one caus on each line.

Immediate Cause (Final disease of conditions) Approximate Interval Between Onset and Death Physician/ diseas r condition resulting in death) r condition (or as a consequence Medical Due to Examiner Sequentially list conditions, Examine r as a consequence of) if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Pregnant at time of death 1 Yes 2 No Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **1** No 1 🗹 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA Certificate: To 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MD 03/16/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) a State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MOSES 2011 <u>March</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** NORTHWEST BANDALLS TOWN 8. Date of Birth
(Month, Day, Year)
10/29/35 5. Social Security Number If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Days Months Country 227-44-2567 75 Director Usual Residence of Decedent show 10c. City, Town or Location Page 1 and 2 should be filled within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho. 10b. County 10d. Inside City Limits Director or 28a-f sh notified a Baltimore Baltimore MD 1 ☐ Yes 2x No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code items 23a or ner must be n Funeral 21244 7101 Bexhill Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status African by 1 Never Married 2 Married Yes 2 KNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🗷 No Specify: Specify: Amer. 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Steel the 12 Laborer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Thweatt William Henry Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 Marks Manor, Randlestown, MD 21132 Wayne A. Jones/Son permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other th 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Dother (Specify) cemetery, crematory or other place)
Woodlawn Cem. 4/5/11 Woodlawn,MD 22. Name and Address of Facility Hari P. Close F. Svs, PA 21. Signature of Fun ral Service Licens 5126 Belair Rd, Balt., MD 21206-5105 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CARDIOVASCULARY Physician/ ATHEROSCUEROTIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and **To the Funeral Director:** After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy □ Live Birth 2 □ Fetal death 3 □ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Medical Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably V Unknown 24b. Were autopsy findings available prior to completion of sause of death? 24a. Was an autopsy performed Yes 2 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Yes 1 ☐ Inpatient 2 YER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) er of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No Natural 5 Pendina М Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined 29a. Certifier Y Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Norse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. leted cause of death (Item 23a) (Type, Print) ROAD OW COUR 31. Date filed (Month, Day, Year) State Registrar

MARCH 22, 2011

а,			Please	State of M		d / Dep	artme	ent of H	lealth ar		_		_		531
	Physici		Registrar 1. Decedent's Name (First, Middle, La Evelyn Mae Kidd	ast)		Ce	niiica	te of L	<u>Jearn</u>		. Date of De Month	D	ay 2011 Year	3. Time	of Death 28 P
	Medi Exami		4a. Facility Name (if not institution, giv Stella Maris Hos	· ·			4b. Cit	ty, Town, or	Location of E		arch 2		altimore	h h	
	Funeral Director	Г	5. Social Security Number 6. S 220-30-0735	Sex 7. Agr 1 M 2 F 8		ast birthday) Yrs.	If Und Month	der 1 Year s Days	If Under 24 Hours	Hrs. 8 Vin.	Date of Bir	th 7 , /4 a9	23 N.C.	thplace (State	e or Foreign a
	taryland 8a-f show ified at	ector	Usual Residence of Decedent 10a. State 10b. County Maryland			y, Town or Lo						_		l .	City Limits
	with the M s 23a or 20 nust be not	Funeral Director	10e. Street and Number 5603 Sinclair Lan	e Apt.B.				Zip Code 206				10g. C	itizen of What Co JSA	ountry?	
р.ш.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	ڇا	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ Wildowed 4 ☐ Divorced	12. Was Decedent B Armed Forces? 1 Yes 2 X If Yes, Give Year or Dates.		5. 13.	If Yes, sp	ecify Cuba	ispanic Origin n, Mexican, P Specify:	? (Specifi uerto Ric	y Yes or No- an, etc.)		14. Race - Ame Black, Whit Specify ack	e. etc.	
11:28 p.1	vithin 72 hou lene. r than "natu the Medical	Be Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 8th grade		ō+)	(Give life. L	kind of v	ise retired)	ation during most of	working			Kind of Business	Industry	
2, 2011	y land Jid be filed v Mental Hyg narked other natic event,	To Be	17. Father's Name (First, Middle, Last) Ned Johnson						18. Mother's Hatti	e Hi	.1.1				
	and 2 shoule Health and 3m 27 is muther traum		19a. Informant's Name/Relationship (Ciara Stewart/Gra 20a. Method of Disposition						<u> </u>				nr Town, State, Zi nore , Mar		
MARCH 2	it. Page 1 arthur of hardents of high right.		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Spec	rify)	Woo	Place of Disp	meenne	ettery		′28/ື¹			d Lawn, Ma	ryland	d
X 0	permit Depar Impor any in		21. Signature of Funeral Service Licer	arris		2 42	2 Name Chatr 210 I	^{and Addres} Nan-Ha Belai	arris I Road	une: Balt	cal Ho imore	me Mai	ryland 2	1206	
	Physician and Examiner e private priva	al Examiner	shock, or heart fallure. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Exical Underlying Cause (Disease or linjury that initiated events resulting in death) Last	a. CEREBR Due to (or as a c. Due to (or as a d. Due to (or as a	OVAS(a consequ a consequ	uence of): uence of):	ACCI	DENT						Interval Onset a	
EVELYN KIDD	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	To Be Completed by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🛣 No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Feta	aldeath 3	Ectopi	c pregnanc (specify)	cy				23d. Date of de Month	livery Day	Year
DD 45 P.O.	uires that the signed by uld be detact	ed by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute 1 □ Yes 2 No 3 □										of death?		
YN KIDD	The law rectate has bee page 2 sho	Complet									24a. Was auto perfo 1 Yes	psy ormed?	death?	topsy findin completion s 2 \(\sime\) No	gs available of cause of
EVELYN	sician certifi	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 👿 No	Hospital:	ont 2 🗆	ER/Outpatie	unt 2 🗆	Oth	ace of Death (-1	6 X Other (Spec	HO.	SPICE
	nding Phy ath. : After this e funeral c	icate: T	27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of inju (Month, Day	rv	28b. Time of injury		28c. Injury	y at	280	d. Describe l			ary) HO	DI TOL
Division	Hospital or Atte 24 hours after dea Funeral Director eted filled in by th	al Certificate:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determined	be 28e Place of Inju			reet, facto	ory, office		28	f. Location (City or Tov		nd Number or Ru e)	ral Route Nu	ımber,
	To the Hosp within 24 hou To the Funer completed fil	Medical	(Check 2 ☐ Medical Examonly one) 3 🗶 Certifying Nu	ysician: To the best of niner: On the basis of e rse Practioner: To the	xaminatior	and/or inve	stigation, death oc	in my opinic curred at th	on, death occu e time, date an	rred at th	e time, date a	and plac ne cause	e, and due to the e(s) and manner as	cause(s) and stated.	
			29b. Signature and title of certifier	CANP				9c. License R/4c	9792			39d. D	ate signed (Mont	n, Day, Year)	
	' ('		30. Name and address of person who JACKIE JONES, C 31. Date filed (Month, Day, Year)		DULA	NEY VA		RD.	TIMON	IUM,	MD 2	1093	3		
	Sta Registr		APR 0.4 2011	A. Negistra	a o oigilal	6									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oung Sok Kim		State of Maryland / Dep 1-For State Registrar	oartment of e <i>rtificate of</i>			2011 eg. No.	10532
Physicia ledical Exami		1. Decedent's Name (First, Middle,Last) Young Sok Kim			2. Date of Deat Month March 26,	h Day Year	3. Time of Death 0252 hrs
		4a. Facility Name (if not institution, give street and number) Johns Hopkins Hospital	4	b. City, Town, or Location of Death Baltimore		4c. County of Death	~
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs 224-17-8095 1 M 2 F	. last birthday) 85 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min	→	h(MM/DD/YYYY) 9. Bir /1926 Foreig	
any		Usual Residence of Decedent 10a. State 10b. County 10c. Cit	ty, Town or Location	on			10d. Inside City Limits
E .	tor	MD N/A	Balti:	more City			1 X Yes 2 No
ith the Mary 23a or 28a notified at	Director	10e. Street and Number 2521 E. Monument Street		10f. Zip Code 21205	10	og. Citizen of What Cour USA	ntry?
r death w	Funeral	11. Marital Status 1 Never Married 2 Married 1 Yes, Sive Year 12. Was Decedent Ever in Armed Forces? 1 Yes 2 M No	If Ye	s Decedent of Hispanic Origin? (Spes, specify Cuban, Mexican, Puerto Yes 2 Y No specify:		White, etc.	can Indian, Black, Sian
2 hours aft "natural"	ed by	15. Decedent's Education (Specify only highest grade completed)	16a. Decedent	t's Usual Occupation (Give kind of vost of working life. DO NOT use reti		16b. Kind of Business/I	ndustry
vithin 72 lene.	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 4	Gaining inio	Military	,	Korean Ma	rines
Ealtimore, MD 21215-0036 emit. Pages I and 2 should be filed within 72 hours afte Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturall", injury or other traumatic event, the Medical Examiner	Be	17. Father's Name (First, Middle, Last) (Unknown)	3× 2=20116= -	18.Mother's Name (Unknown	1)		
AD 21 2 should n and Me 27 is ma matic or	ဥ	19a. Informant's Name/Relationship (Type, Print) Kyu Q Kim (Son)		Address (Street and Number or F E. Monument Stre		ber, City or Town, State $1 { t timore,} \ { t MD}$	
Baltimore, MD 2' permit. Pages 1 and 2 should Department of Health and Mc Important: If item 27 is mainjury or other traumatic er	1	20a. Method of Disposition 20b 20b 1 XXBurial 2 Cremation 3 Removal from State		tion (Name of cemetery,	Date	20c. Location - City or	
Baltimo permit. Pag Department Important: injury or ot		4 Donation 5 Other Specify: Me	adowridg	e Memorial Park	3/30/11	Elkridge,	MD
		23a. Part I. Enter the disease, or complications that caused the deat		ame and Address of Facility ry L. Kaufman Fu 50 Washington B1			21075 Approximate Interval
Physician /Medical =xaminer		failure. List only one cause on each line. Immedian Cause (Final disease a Multiple Injuries	TI. DO NOT EITHER TH	e mode or dying, such as cardiac o	respiratory arre	ist, Shock, or Healt	Between Onset and Death
Zammer		or condition resulting in death) Due to (or as a consequence Sequentially list conditions, b.	of):				
	niner	if any, leading to immediate cause. Enter Underlying Cause Usease or injury that initiated	of):				
uted nd ransit	ledical Examiner	events resulting in death) Last Due to (or as a consequence d.	of):				
60, tte be executed hysician and burial - transit	edica	UNPENDED AMENDED					
Box 6876 e death certificate the attending phy ed for use as the	21	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pre	2 Feta	al death 3 Ectopic pregna	incy	23d. Date of delivery Month	year Year
the deatl	Phys	1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not		nderlying cause given in Part I.	23e. Did tol	bacco use contribute to	the cause of death?
S, P.O. Lires that the signed by d be detach	<u>a</u>					2 ✓ No 3 Prob	ably 4 Unknown
iof Vital Records, P.O. ing Physician: The law requires that the After this certificate has been signed by uneral director, page 2 should be detach.	Completed				24a. Was a autops perform	prior to c ned? death?	topsy findings available ompletion of cause of
Vital Rec ysician: The his certificate director, page	Be	25. Was case referred to medical examiner?		26 Place of Death (Check	1 Yes 2	P No 1 ✓ Ye	s 2 No
n of Vit ding Physic L. After this	의	1 Yes 2 No Inpatient 2 2 27. Manner of Death 28a. Date of Injury	ER/Outpatient 28b. Time of In			Residence 6 Other	
Division (Isl or Attending Isl after death. al Director: Asterding the further for the further furth	ation	1 Natural 5 Pending Mar 26, 2011 Pending 2 ✓ Accident Investigation	0055 hrs	1 Yes 2 ♥ No	Pedestrian s	truck by train	
Division pital or Attencours after death reral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined (Specify) Train Trac		t, factory, office building, etc.	or Town, St	treet and Number or Rui ate) hterlocking, Baltimore	
Division of Vital Records, P.O. Box 68760, To the Hospital or etificate be executed within 24 hours allor After this certificate has been signed by the attending physician and completely filled in by the funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - trans	Medical C	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and manner stated.					
F & F &	¥	29b Signature and title of certifier		29c. License number O.C.M.E.		29d. Date signed (Mon	eth, Day, Year)
	-	30. Name and address of person who completed cause of death (Itel	m 23a)	0.0.W.E.			
Sta	1/2	Donna M. Vincenti, MD Assistant Medical Exa 31. Date filed (Month, Day, Year) 32. Registrar's Signa		Penn Street, Baltimore, M	D 21201		
Regist	_	APR 0 4 2011 /2 / A	arked				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 2:00 A M March Marv Palmer Kroh Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Westminster Carroll Luth. Village Hlth. Care Ctr. 8. Date of Birth (Month, Day, Yes Aug. 30 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) Funeral Days Year) 1 □ M 2 🔀 Months Hours Min. Maryland 1917 **Director** 213-03-1234 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Heath and Mental Hygiene. ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Westminster Maryland Carroll 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 301 St. Luke Circle 21158 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Black, White, etc. 1 Never Married 2 X Married Completed by Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education Office manager/secretary

Office manager/secretary

Owner/operator (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) garage/print shop 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Ada Willett Frank Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Westminster, MD 21157 1806 Bollinger Rd. Earl M. Palmer/ nephew Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 3/30/2011 nr. Linwood, MD 4 Donation 5 Other (Specify) Pipe Creek Cemetery 21. Signal of Funeral Service Lice 22. Name and Address of Facility Hartzler Funeral Home 310 Church St. New Windsor, MD 21776 d the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complications that can shock, or heart failure. List only one cause on each Approximate Interval Between Opset and Death Immediate Cause (Final Physician Pa disease or condition Medical resulting in death) Due to or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last the attending physician a hed for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 m Month Day Year Pregnant at time of death No page 2 should be detached Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has performed' 1 Yes 2 No Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Hospital Other 2 🗆 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA ပ 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: 24 hours after death. Funeral Director: After 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide filled in by determined City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 29d. Date signed (Month, Day, Year) 29b. Signature and title of cert 28 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) lbu 31. Date filed (Month, Day, Year) State APR 0.4 201 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2^{Day} March 20°1'1 1:32 Margaret Kubicek Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Montgomery General Hospital 01ney Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs, last birthday, **Funeral** 1 □ M 2 🕅 F Days Hours Austria Months Min. November 25, 1921 577-50-4812 89 Director Usual Residence of Decedent 10b. County should be filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho ədical Examiner must be notified at 10a. State 10d. Inside City Limits 10c. City, Town or Location Director 1 Yes 2 No Maryland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 14431 Traville 20850 United States Gardens Circle 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: White Completed 3 X Widowed 4 □ Divorced other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than ' College (1-4 or 5+) Elementary/Seconday (0-12) Child Care Nanny 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Theresia Kodritsch Leopold Graf 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) / Daughter 6275 Walnut Lane, Redwood Valley, California, 95470 Fran Laughton Important: If item any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of Competer, crematory or other place)
Montgomery
Crematorium, Inc. 20c. Location - City or Town, State permit. Page 1 a Department of h Marchate 31, 1 🗆 Burial 2 ื Cremation 3 🗀 Removal from State 2011 4 ☐ Donation 5 ☐ Other (Specify) Bethesda, Maryland Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home/Rockville, Inc. M01305 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Eyer th. disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sepsis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Aspiration Drumonia Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed muonerosis signed by the attending physician and deed be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 5 Other (specify) Year Pregnant at time of death P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 this certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 🗌 Yes Certificate: To 1

✓ Inpatient 2

ER/Outpatient 3

DOA completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred To the Hospital or Attending F within 24 hours after death.

To the Funeral Director: After 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 K Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 2 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie Bichhum 754996 March 26 Winh 2011 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print)

Right M. Dinh 18101 Prince Philip 20832 rive 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 29 2011 7:55 P M SARAH KROIZ M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 □ M 2 🗓 F Months Days Hours 11726/1914 Director 218-46-6462 96 Usual Residence of Decedent 28a-f shov 10a. State 10b. County at 10c. City, Town or Location Director 10d. Inside City Limits the Medical Examiner must be notified 1 X Yes 2 ☐ No BALTIMORE MD N/A 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2211 W. ROGERS AVENUE USA 21209 or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black White etc. ģ 1 Never Married 2 Married 21215-0036 within 72 hours after If Yes, Give 1 Yes 2 XNo Specify. "natural", Specify Completed 3 √2 Widowed 4 □ Divorced WHITE Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. is marked other tha 12 OWN HOME HOMEMAKER Be Maryland 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ 2 should be STEIN **METZKER** FANNIE other traumatic LOUIS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 11802 GEORGES MILL ROAD, LOVETTSVILLE, VA 20180 LOUIS KROIZ/SON Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗀 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) BETH TFILOH CEMETERY: 04/01/2011 BALTIMORE, MD Signature of Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death evnonio -Ph sician/ disease or condition resulting in death) weck Medical Die to (or as a consequence of) Examine month Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (b as a consequence of the burial physician Physician/Medical Box 68760 as attending IF FEMALE use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No õ Dav Pregnant at time of death signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Demendo Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Physician; The law autopsy page certificate 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: မှ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, After this Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending entry 5 Pending ☐ Natural work? 1 ☐ Yes 2 🙀 No February 28 284 Fall Accident Investigation within 24 hours after deat To the Funeral Director: the Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State)
2211 W. Rosenzs AVC, Rulima 28e. Place of Injury - At home, farm, street, - ctory, office filled in by 4 Homicide determined building, etc. (Specify) none Medical certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie

Registrar

State

0

31. Date filed (Month, Day, Year)

completed cause of death (Item

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year Physician/ 2011 8:00A March ROSE AMELIA MAGGIO LaDECCA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HART HERITAGE ASSISTED LIVING Forest Hill Harford County 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Yea Days Months Hours 1 □ M 2 🗶 F Director 95 1915 461-34-2886 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 X Yes 2 No Maryland N/ABaltimore City 10e. Street and Number 10g. Citizen of What Country? 1107 Andover Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status 1 and 2 should be filed within 72 hours after deat of Health and Mental Hygiene. item 27 is marked other than "natural", or iten other traumatic event, the Medical Examiner. Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done of life, DO NOT use retired) during most of working Elementary/Seconday (0-12) College (1-4 or 5+) Insurance 12 Office Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Rosario Maggio Rosaria Maggio 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other tra Mr. Richard E. Solli (Nephew) Beech Tree Court, Lutherville, MD 21093 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State cemetery, crematory or other place) 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Holy Redeemer Cemetery 4/2/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Fundal Service Vice/See

Martin D. Lawson MITCHELL-WIEDEFELD FUNERAL HOME, INC. 6500 York Road, Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition AND STAGE Physician/ Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Month Year signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, 1 🗌 Yes 2 No 3 □ Probably 4 □ Unknown certificate has been si irector, page 2 should Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? 2 🗆 No 1 Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I 1ssiste D Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARPUALI RO BE(DER MA 21014 ALGRAP SPAMES 615 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30 Day 201 Team Harriette Charlesworth Lanning 10:15 A M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Manor Care - Potomac Potomac Montgomery If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🖾 F Days Months Hours Min. November 12, 1918 New York 079-16-5104 92 Director Usual Residence of Decedent or 28a-f shov notified at shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2X No Maryland | Montgomery Potomac 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? ò "natural", or items 23a or edical Examiner must be Funeral 20854 United States 10301 Crown Point Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2 🖾 No Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) High School Teacher age 1 and 2 should be filed with out of Health and Mental Hygien nt: If item 27 is marked other 1 y or other traumatic event, thy Be 17 Father's Name (First Middle Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lucy Carmichael Fred Charlesworth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Ruth Benson / Daughter 10301 Crown Point Court, Potomac, Maryland 20854 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ApriPate 9. permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗀 Removal from State Parkview Cemetery 2011 4 Donation 5 Other (Specify) Hastings, Nebraska 21. Signature of F neral Service yet 22. Name and Address of Facility Robert A. Pumphrey Funeral Home, Bethesda—ChevyChase,In 7557 Wisconsin Avenue Bethesda, Maryland 20814 MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Dementia Advanced Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed anding physician and use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No for Month Year Day detached g Unknown g Unknown cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy death? 1 Yes 2 No 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital: Other: 2 No မြ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural iniury 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, filled in by determined City or Town, State, Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed only one 29b. Signature and title of certifier D50534 Momas Masterson us 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) THOMAS MASTERSOWND, 6858 Old Dominion Dr#104, McLean, UA 22101 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ CHARLES ciw3) 2011 4:53 AM MARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE WASHINGTON MEDICAL CENTER GLEN ANNE ARUNDEL BURNIE 5. Social Security Number 8. Date of Birth (Month, Day, Year) Feb 4, 1946 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 **XX**M 2 □ F 65 Months Country) 032-34-2945 Director Usual Residence of Decedent fshow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at Director MD Anne Arundel Pasadena 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21122 USA 8355 Forest Glen Dr 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces' 1 Never Married 2 XXMarried þ Yes 2 If Yes, Give 2 No 3altimore, Maryland 21215-0036 1 ☐ Yes 2xx No Specify: Specify: White 3 🗌 Widowed 4 🗌 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hour.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medicall any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) CHARLES Engineering Facility Mgr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Joanne Piraino Charles E. Lewis, Sr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8355 Forest Glen Dr., Pasadena, MD 21122 Marcia A. Lewis 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Kemoval from State 4 Donation 5 Other (Specify) Mar 31, 2011 Baltimore, MD Baywiew Crematory ture of Funeral Service 21. Sign 22. Parkartundera Pf Hollie, P.A. 426 Crain Hwy s., Glen Burnie, MD 21061 on complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, let only one cause on each line. 23a. Part 1. Enter the diseas shock, or heart failure Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician ST ECEUATION MYOCARDIAL INFARCTION disease or condition resulting in death) 2AUOH 21 Medical Examiner 2843401 COROHARY ARTERY DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of burial-transi that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year 4 Pregnant : 9 Unknown Pregnant at time of death 5 Other (specify) Yes 2 No 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, CUHE CANCER, COPD cate has been signated by page 2 should by Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate the completed filled in by the funeral director, page. ☐ Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 📉 No ဂ္ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 🙇 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year, 10065314 OH CINGONNE DES CIONADOLOS HO WARCH 39, 3011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CUILLERMO JOSÉ CIMPERECO 301 HOSPITAL DRIVE, GLEH BURNIE, MD 20161-5803

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 16a1 3 2 2 211 **Physician** Month LEMON 8:45AM JEANETTE MARCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 203P. 130N SECOURS BALTIMORE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 04/25/1955 6. Sex 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Months 1 □ M 2 🕱 F Maryland Director 55 216-68-7491 Usual Residence of Decedent 10d. Inside City Limits 10a, State 10c. City, Town or Location show is marked other than "natural", or items 23a or 28a-f shov aumatic event, the Medical Experiment inust by notified at Director 1 TxYes 2 □ No N/A MD Baltimore 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21229 U.S.A. 105 N. Kossuth St. by Funeral within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black. White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify. Specify: 3 Widowed 4 Divorced Black Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, Inc. M. College (1-4or 5+) Bank Banking 12th Grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Catherine Harven Ollie Lemon ပ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Georgette Walters(daughter)105 N. Kossuth St., Baltimore, MD 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/09/11 Baltimore, MD Mt. Zion Cem. 21. Signature of Funeral Service Licensee Joseph H. Brown Jr. Funeral Home PA 2140 N. Fulton Ave., Baltimore, MD 21217 Ellamo 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PN4 EMONI /Medical Due to (or as a consequence of): **Examiner** CARCINUSTA NASOFHARYNSEA2 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner ARTER105021EROTIC KEART attending physician and for use as the burial-trar Due to (or as a consequence of): Box 68760 Hospital or Attending Physician: The law requires that the death certificate be Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) 1 ☐Yes 2 ☐ No signed by the a Ö 9 Hinknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ MALNUTRITION 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 🗆 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 딸Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA Medical Certification: To s after death.

I Director: After this ed in by the funeral di 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Momicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) within 2 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D 23300 MARCH 30 2011 MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13 しい ろをとめ リアゴ , PATEL ZONN 139250 SUDKIR

DHMH 17 Rev 1/2001

Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 3:21pm Albert Louis Mercer, Jr. 201 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** BALTIMORE HOSPITAZ SINAT 5. Social Security Number If Under 8. Date of Birth (Month, Day, Year) 9. Birthplace (Sta Country) March 28, 1940 Maryland Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Hours 1 M 2 ☐ F Months Director 216-36-0580 71 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f shov notified at 1 ☐ Yes 2 No Directo Maryland Baltimore Parkville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filed within 72 hours after death with i Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or any lajury or other traumatic event, the Medical Examinar Insist by once. Funeral 3521 Woodring Avenue USA 21234 12. Was Decedent Ever in U.S. Armed Forces? 12 Yes 2 ☐ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Black Baltimore, Maryland 21215-0036 1 □Yes 2 No If Yes, Give Year or Dates: Specify þ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 11th grade Maintenance Speacialist Broad Mead, INC 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Albert Louis Mercer, Sr. Edith Bond 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pearlie Jean Mercer/ Wife B521 Woodring Avenue Baltimore, MD 21234 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4-4-2011 № Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest Vet. Cemetery Owings Mills, MD 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licensee, 5240 Reisterstown Road Baltimore, MD 21215 usur 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, enock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician CARDIAC ARRAYTMIA disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner ATHEROSCIBROTIC HEAVET DISEASE if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine ng physician and as the burial-transi Due to (or as a consequence of): Box 68760 Physician/Medical the attending p IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 5 ☐ Other (specify) signed by the a Ö □Yes 2□No 9 Unknown 9 Unknown σ. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown s peen s Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed r this certificate h ral director, page of Vital 1 ☐ Yes 2 ☐ No 1 ☐Yes 2 No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1∰Yes 2 No 1 ☐ Inpatient 2 등 ER/Outpatient 3 ☐ DOA Certification: To After thi funeral of 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation n 24 hours after death.
he Funeral Director: #
pletely filled in by the fi 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Medical 29a, Certifier 😰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the within 2 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number ause of death (Item 23a) (Type, Print) JAOUS HOSPITAL OF BAZTIMORE State Registrar

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			Registrar 1. Decedent's Name (First, Middle,	(act)		Cen	tificate of L	<i>Death</i>					
-	Physicia Media		BARBARA		1	MAU	PiN		2. Date of De Month Mmc14	Day	Year	3. Time of Death 10.03 AM	
	Examir	ier	4a. Facility Name (if not institution, HABON HO	1etim,			4b. City, Town, or	Location of Death	1	4c. Co	unty of Deat	th	
	Funeral Director		5. Social Security Number 218-28-8971	6. Sex 1	e (In yrs. Iasi 76	t birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi			thplace (State or Foreign untry) MD	
	how at	ř	Usual Residence of Decedent 10a. State 10b. County		10c. City	Town or Loc	ation					10d. Inside City Limits	
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	eath w	Funeral	11. Marital Status	12. Was Decedent B	Ever in U.S.	13. W	/as Decedent of Hi Yes, specify Cuba		pecify Yes or No-		Race - Ame		
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Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationsh Brenda Harmon -				Address (Street & Washingt						
nore,	age 1 and ant of Hea it; If item y or othe		20a. Method of Disposition 1 ▼ Burial 2 ☐ Cremation	3 ☐ Removal from State	cen	netery, crema	ition (Name of atory or other plac	e) Pk 03-	Date 16-2011	l	-	Town, State Maryland	
Baltir	Departme Importar any injur		4 Donation 5 Other (Sp 21. Signature of Funeral Service Li		Tieac	22.	Name and Addres	ss of Facility Ga	ry L. K	aufman	Funer	MD 21075	
		Н	23a. Part 1. Enter the disease, or o	complications that caused	I the death. I				-		ruge,	Approximate	
, F	nysician/		shock, or heart failure. List or Immediate Cause (Final disease or condition	nly one cause on each line).							Interval Between Onset and Death	
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200	cate be physic the b	edic		d				- All	HILFICATION A	- V-			
Division of Vital Records, P.O. Box 68760	To the hospital or Attending Physician; The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outcome of 1 ☐ Live Birth and 1 ☐ Pregnant at 9 ☐ Unknown	2 🗌 Fetal d	leath 3	Ectopic pregnanc Other (specify)	у		23d.	. Date of del Month	ivery Day Year	
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ıta :	sician certifi irector	m	25. Was case referred to medical examiner? 1 Yes 2 No	Hospital:			Otho	ace of Death (Checer:					
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	ne nospi in 24 hou ar Funer pleted fill	Medical	(Check 2 ☐ Medical Ex	Physician: To the best of r aminer: On the basis of ex Nurse Practioner: To the b	amination ar	nd/or investig	ation, in my opinio	n, death occurred a	at the time, date a	and place, and	due to the c	ause(s) and manner stated.	
	To the		29b, Signature and title of certifier				29c. License	number		29d. Date sig	gned (Month	, Day, Year)	
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	Stat Registra	_	31. Date filed (Month, Day, Year)	2011 32. Registrar	r's Signature		rked						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March 30 Day 2011 Physician/ 9:00 A Phillip Frederick Martin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** Days Hours Min. 202-36-0789 1 📉 M 2 🗆 F 58 024927744953 Scranton, PA Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic and any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event. 10a. State 10b. County 10c. City, Town or Location Director Maryland 1 ☐ Yes XX No Howard Hanover 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code Funeral 6465 Anderson Avenue 21076 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by ☐ Yes Yes, Giv 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify Specify: 3 Widowed 4 Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Heavy Equiptment Operator Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Frederick Martin Georgina Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda Lee Martin / Wife 6465 Anderson Ave, Hanover, Maryland 21076 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory 4/2/2011 Glen Burnie, Maryland 22. Name and Address of Facility Gary I. Kaufman Funeral Home Inc. 7250 Washington Bivd., Elkridge, Maryland 21075 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complicatives that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final METASTATIL Physician/ Lo lou Cancer disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that be interest cause) Completed by Physician/Medical Examiner Due to (or as a consequence of): burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Month Year Pregnant at time of death signed by the ar Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed Yes 2 1 Yes 2 No Division of Vital 25. Was case referred to medica funeral director, Certificate: To Be 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\overline{\overlin ER/Outpatient 3 DOA 1 Inhpatient 2 🗆 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending work after death.

Director: Aft 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 hou To the Fune completed fi 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) Mauch 30 2011

Registrar

DHMH 17 Rev 7/2009

State

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 30 Pay 201T 3:00P M Marie A. Mattes Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Dundalk Baltimore Co. Heritage Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Maryland 8. Date of Birth **Funeral** 7. Age (In yrs. last birthday) 1 □ M 2 1 F Min. 5-4-1917 93 2<u>12-05-1657</u> Director Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If ifew 27 is marked of other than "natural", or items 23a or 28a-f sho amportant: If item 27 is marked of other than "natural", or items 5.80 or 28a-f sho in injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/ABaltimore City 1 X Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 310 S. 21224 Kane Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 🗌 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: White Completed 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Seconday (0-12) Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Cunnigunda Foehrkolb John Conrad Mack 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Clear Lake Lane Middle River, MD 21220 Marie Wilson-Daughter 7533 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗀 Removal from State Middle River, MD 4 Donation 5 Other (Specify) Holly Hill Memorial Gardens 22. Name and Address of Facility Kaczorowski Funeral Home, PA any in MD 21222 1201 Dundalk Avenue Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each lin. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition AMON Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Physician/Medical Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transi-Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 pertension 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No death? 1 Yes 2 🔀 No Division of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2X No Other: 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Mursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27, Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work? 1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖫 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie

State Registrar 31. Date filed (Month, Day,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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	State of Maryland / Department of Health and Mental Hygiene

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	F	legistrar 1. Decedent's Name (First, Mic	ddle Last)		Corti		Bouin			2	. Date of De	ath		3. Time of Death
Physician I Examin	_	Douglas Wil		rgan							Month March 27	7, 20	y Year 11	0855 hrs
		4a. Facility Name (if not institu				4	b. City, Tow		ocation of	Death			4c. County of Dea Baltimore Co	
		34 Shipway					Dundal					Sat a		
Funeral		5. Social Security Number	6. Sex	7. Age (1	-	st birthday)	If Under 1	Year	If Under Hours	24Hrs. Min.			1For	Birthplace (State or reign
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		Usual Residence of Decedent		110	c City T	Town or Locati	on							10d. Inside City Limits
w any		10a. State 10b. Coun	•			ndalk								1 Yes 2 X No
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death with the Maryland or items 23s or 28s-f show must be notified at once.	a Ö	34 Shipway 11 Marital Status	12. Wa	as Decedent Ev	er in U.S	6. 13. Wa	s Decedent	of Hisp	anic Origi	in? (Spe	cify Yes or I	No-	14. Race - Am	nerican Indian, Black,
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fler de		3 Widowed 4	Divorced If Yes, G				Yes 2 X						Specify: Wh	
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Feral Sen	ice Licensee			22. 1	Name and A	ddress	of Facility	Kac	zorov	√S K	1 rune	rai nome, ra
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Examiner		Immediate Cause (Final dise or condition resulting in deat	ase a.				thado	ne a	and A	LCOL	IOT TI	tox	cication_	
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68 certifi nding ise as 1	ian	past 12 months?	4	Live birth Pregnant at ti	me of de		etal death ther (Speci	- 1		o program	,			
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Vital Records, P.O. Box 68760 hysician: The law requires that the death certificate this certificate has been signed by the attending physidirector, page 2 should be detached for use as the bildirector, page 2 should be		Part II. Other significant co	nditions contrib	outing to death	but not re	esulting in the	underlying	cause g	given in Pa	art I.				te to the cause of death? Probably 4 Unknown
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Division of Vital Records, talor Attending Physician: The law requires after death. *I Director: After this certificate has been siled in by the funeral director, page 2 should the funeral director, page 2 should	Certification:		Could not be	Specify)		sidence					34 S	n, Sta hip	way Dun	ıdalk, Md.
Hospi 24 hou Funer rely fil		29a. Certifier (Check only 1 Certifying	ng Physician: To I Examiner: On the	the best of my	knowled	lge, death occ	urred at the	time, d	ate and pl	lace, and	due to the	cause(late ar	(s) and manner as nd place, and due	stated. to the cause(s)
To the within 2 To the complet	Medical	one) 2 ✓ Medical 29b. Signature and title of co	and m	nanner stated.	/				se number					(Month, Day, Year)
	2	230. Signature and little of C		X	/	7		O.C.	M.E.				March 28, 20)11
		30. Name and address of pe	arson who comple	ated cause of	eath (Iten	n 23a)		-	70.70		_			
2	(r)	Zabiullah Ali, M.D.		Medical Ex	amine	r 111 Pe	nn Stree	t, Bal	timore,	MD 21	201			
s	tate	31. Date filed (Month, Day,	/ear)	32. Registrar	's gnat	parke	1							∪∪ (Vic
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Month Catherine Nichols 9:35 P^{M} March Medical 4a. Facility Name (if not institution, give street and number) 5802 Carter Ave. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carter Ave. Baltimore 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Aug. 11, Year) 918 Country 1 □ M 2 □ F Days Hours Min. Months 219-12-5964 92 Yrs Director Usual Residence of Decedent 23a or 28a-f show 10c. City, Town or Location 10a. State 10b. County 10d, Inside City Limits injury or other traumatic event, the Medical Examiner must be notified at Director MD Baltimore X☐ Yes 2☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5802 Carter Ave. 21214 USA or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S 14. Race - American Indian, 11 Marital Status Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black "natural", 3 Widowed 4 Divorced Completed Year or Dates. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Baltimore City and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Public School Custodian Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ should be Johnny Harrison Dora Scott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is Jacqueline Nichols (daughter) 5802 Carter Ave. Balto, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Apr. 8, 201 1 N Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garrison Forest Veteran Cem/ OwingsMills,MD ZName and Address of Facility ruggs Funeral Home Signature of Funeral Service Licensee Preston St. Balto, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-transit Exam that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy Month Year Day ed by the detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown P.O. s been signed to should be deta Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à the Hospital or Attending Physician: The law requires Records, 4 Unknown 1 Yes 2 No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performed Yes 2 N 25. Was case referred to medical 26. Place of Death (Check only one) **Division of Vital** director, Be examiner? Other: 2 No ည 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) funeral 28c. Injury at work?
1 Yes 2 No To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier H0046961 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Heartland Hospice, 4 & Rolling Crossroads
Baltimore MD21228 D.D. Haw Kins, om-e 31. Date filed (Month, Day, Year) -

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year 1186PM Louise Elizabeth Reid 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hes Baltimere altimor 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Mary.land 8. Date of Birth **Funeral** 1 🗆 M 2 🗹 F Months Days Hours Min. OCH 1924 Director 86 213-20-5592 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits 1 1 Yes 2 □ No MD N/A Baltimore 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral USA 4913 Park Heights Avenue 21215 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Eyer in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: 3 ☑ Widowed 4 ☐ Divorced Specify: Black Completed and Mental Hygiene.
is marked other than "natur aumatic event, the Medical." 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Grade Housewife Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 0 Page 1 and 2 should be ment of Health and Ments Catherine E. Rankin James E. Carter traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 4913 Park Heights Avenue Baltimore, Maryland 21215 Frances Curtis - Daughter Important: If item 2 any injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State Baltimore Nat'l Cometery ! Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 4-4-2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Chatman-Harris Funeral Home 5240 Reisterstown Road Baltimore, Maryland 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. such as cardiac or respiratory arrest. Approximate Interval Between One et and Leath Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, feading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of). the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Yes 2 No been signed by the should be detached 9 Unknown Part II. Qther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? The 1 Yes 2 No 25. Was case re err d to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 THO Other: ၉ 1 Dipatient After this 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred s after dea... ral Director: After 1 Natural (Month, Day, Year) 5 Pending injury Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical 29a. Certifier 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and

Registrar

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Date filed (Month, Day, Year)

M

32. Registrar's

LE3-000

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11-02429 Unk Unk

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 201115547

	1- For Stats Registrar	Certificate	of Death	Reg. No.	
Physician				Date of Death Month Day Year	3. Time of Death
Medical Examine	r Durell Roach			March 29, 2011	1455 hrs
	4a. Facility Name (if not institution, give s	reet and number)	4b. City, Town, or Location of Death		ath
	Johns Hopkins Bayview Med	ical Center	Baltimore	N/A	
Funeral	5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)			Birthplace (State or
Director	219-94-4495 INM	2 F 31	Months Days Hours Min	11/18/79 For	eign Countr M D
	Usual Residence of Decedent	2	115.		
any	10a. State 10b. County	10c. City, Town or Lo	cation		10d. Inside City Limits
	mD N/A	Baltimo			1 X Yes 2 No
Aaryland 28a-f show 1 at once.		Duz ez mo.		The and the control of	
the Maryland a or 28a-f sh lifted at one	10e. Street and Number		10f. Zip Code	10g. Citizen of What Co	ountry?
ith the Maryland 23a or 28a-f sho notified at once.		Ave - Apt. 8	21206	USA	
r death with or items 23	11. Marital Status		Was Decedent of Hispanic Origin? (S		erican Indian, Black,
cath riter	1 Never Married 2 Married	Armed Forces? Yes 2 X No	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.) Africa	in
fer o		Yes, Give Yaar 1	Yes 2 X No specify:	Specify: Am	ner.
urs aft tural" amine			dent's Usual Occupation (Give kind of		ss/Industry
2 ho	Elementary/Secondary (0-12)	College (1-4 or 5+)	most of working life, DO NOT use ret	Construc	tion
5-0036 ed within 72 hour lygiene. other than "natt the Medical Exal	12	Lai	oorer		
d wit	17. Father's Name (First, Middle, Last)		18.Mother's Name	(First, Middle, Maiden Surname)	
11215-0036 Id be filed within 72 hours a fental Hygiene. arked other than "natura event, the Medical Examin			Janice	Walker	
1 21 215-0036 ould be filed within 7 d Mental Hygiene. 3 marked other than ite event, the Medica	19a. Informant's Name/Relationship (Type	Print) 19b. Mai	ling Address (Street and Number or	Rural Route Number, City or Town, Sta	ate, Zip Code)
O & B is is	Jacqueline Antho	1110	Plainfield Av	e,Balt.,MD 212	06
e, M l and 2 Health litem 2	20a. Method of Disposition		position (Name of cemetery,	Date 20c. Location - City	or Town, State
Baltimore, permit. Pages I as Department of He, Important: If ite	1 K Burial 2 Cremation 3		other place) 4 / 6	5/11 Balt.,M	ID
imore Pages nent of F.	4 Donation 5 Other Specify:	Mt. Zio			
Baltimore permit. Pages Department of H Important: If is	21. Signature of Fun Service License	22	2. Name and Address of Facility Har	i P. Close F.S Balt.,MD 21206	VS, PA
E E C B CO	NE C				-5105
Physician	23a. Part I Enter the disease, or complication failure. List only one cause on each		er the mode of dying, such as cardiac	or respiratory arrest, shock, or heart	Approximate Interval Between Onset and
Medical		ultiple Gunshot Wounds			Death
!xaminer		e to (or as a consequence of):			
	Sequentially list conditions, b				
ž l		e to (or as a consequence of):			
	cause. Enter Underlying Cause (Disease or injury that initiated				
ted Insit	events resulting in death) Last	e to (or as a consequence of):			
760, ficate be executed g physician and the burial - transit	d				
8760, ificate be execut by physician and sthe burial - tra	UNPENDED	MENDED			
8760, ifficate be ng physic as the bur	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregnancy	Fetal death 3 Ectopic pregn	23d. Date of deliv	· ·
68 Sertif	past 12 months?			ancy Month	Day Year
Box 687 c death certific the attending of for use as the	1 Yes 2 No 9 Unknown	4 Pregnant at time of death 5	Other (Specify)		
by the attending the death certion by the attending to the death certicity.	Part II. Other significant conditions co		e underlying cause given in Part I.	23e. Did tobacco use contribute	to the cause of death?
P.O. s that the med by detach		with Dating to death Dat Het Pesatting with	so an early mig occurr given in the con-	1 Yes 2 No 3 P	robably 4 Unknown
uires I	B 				autopsy findings available
Records, The law requires ficate has been sig				autopsy prior t	to completion of cause of
ecc ne lav te ha				performed? death 1 ✓ Yes 2 No 1 ✓	
tal Relian: The certificate ector, page			26.Place of Death (Check		
ician ician s certification R	examiner? Hos	pital: 1 Inpatient 2 ✔ ER/Outpati		ng Home 5 Residence 6 Ot	her:
Division of Vital Records, P.O. tal or attending Physician: The law requires that it is after death. al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detachartification: To Re Commission by Establish P. B.		28a. Date of Injury 28b. Time		28d. Describe how injury occurred	
ding Ph. h. After t	1 Natural 5 Pending	Mar 29, 2011 1434 hrs	1 Yes 2 ✔ No	Subject shot	
Sior Attend r death ector: by the	2 Accident Investigation	CO. Blace of taken At home form		28f. Location (Street and Number or	Pural Poute Number City
ivi	3 Suicide 6 Could not be	28e. Place of Injury - At home, farm, s	treet, factory, office building, etc.	or Town, State) 5424 Sinclair Lane, Baltimore, M	
	4 Homicide determined	(Specify) Parking Lot			
S Fundament		 To the best of my knowledge, death or in the basis of examination and/or invest 			
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner:0	n the basis of examination and/or invest nd manner stated.			
	29b. Signature and title of certifier		29c. License number	29d. Date signed (i	
	Will come	Mi	O.C.M.E.	March 30, 201	1
2041.	30. Name and address of person who cor	npleted cause of death (Item 23a)			
h.	Russell Alexander MD. As	sistant Medical Examiner 1	11 Penn Street, Baltimore, M	ID 21201	
Stat	e 31. Date filed (Month, Day, Year)	32. Registrar's Signature			
Registra		un p. garker			

State of Maryland / Department of Health and Mental Hygien 20 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year 2:60 A M **Physician** 6 Mary G. Stills /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Manorcare Ruxton 8. Date of Birth (Month, Day, Year) June 25,1917 If Under 1 Year lf Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Davs Hours 1 □ M 2 🗓 F Towson 93 Director 213-16-6813 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10a State 10b. County 10c. City, Town or Location d other than "natural", or items 23a or 28a-f show event, the Medical Exercitors roughly as 1 ☐ Yes 2 → No Director Maryland Anne Arundel Odenton 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21113 Funeral 150 Leeds Creek Cricle 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐XNo
If Yes, Give
Year or Dates: 14. Race - American Indian, Black White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 □Yes 2 No Specify: Black Baltimore, Maryland 21215-0036 Specify: <u>გ</u> 3 Nidowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) permit. Pages 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "in any njury or other traumatic event, it is Media. Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer Private Homes 10th grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mary Grace Johnson ೭ Thomas Jordan Norris 19a. Informant's Name/Relationship (Type. PrinGreat Niece19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 150 Leeds Creek Circle Odenton,MD 21113 Ottawana Shanelle Cooper 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Arbutus Memorial Park 3-31-2011 Baltimore, MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Chatman-Harris Funeral Home 21. Signature of Funeral Service Licers 5240 Reisterstown Road Baltimore, MD 21215 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

In undiate Cause (Final sease or condition resulting in death)

a. Provide (Note as a sease) Approximate Interval Between Onset and Death **Physician** /Medical Due to (or as a consequence of): Examiner Pertons Se uentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) law requires that the death certificate be executed and Due to (or as a consequence of) burial-Box 68760. attending physician for use as the buria Physician/Medical 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No signed by the a P.O. 9 Unknown 9 I Unknown 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy The 1 ☐ Yes 2 ☐ MO certificate 2 JAK 1 ☐ Yes Hospital or Attending Physician: 24 hours after death. Funeral Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Aursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ 110 1 Inpatient 2 ER/Outpatient 3 DOA ို funeral 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death Certification: 1 Watural 5 Pending investigation 1 □Yes 2 □ No 2 Accident the 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 ☐ Homicide 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely (Check only one) and manner stated. within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Dundark Ave, Dundark Ctrus Asadi 3029 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last 2. Date of Death 3. Time of Death Physician Dertha JariE 09:10 AM 201 lanc /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltimore Hos Mta Social Security (I) mber 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Sex **Funeral** Months Days Hours Min 1 M 2 F 213 .28.1208 Yrs. Director Mar land Usual Residence of Decedent 10a State 10b. County show 10c. City, Town or Location 10d. Inside City Limits ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the "faction" Exeminar must be redfied at Director 1 ☐ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Lane 21228 Ianne Funeral filed within 72 hours after death v Hygiene. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No \$ Specify. Specify: 3 Widowed 4 □ Divorced Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surr Be Pages 1 and 2 should be 1 nent of Health and Mental ൧ Informant's Name/Relationship (Type. permit. Pages 1 and 2 shr Department of Health and Important: If item 27 is m 19b. Mailing Address (Street and Number or Rura Poute Number, City or Town. MD 3190 anne atonsville 20a. Method of Dispesition

1 Burial 2 Ocemation 3 Removal from State altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date Baltimore-Washington mate aurel, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Adress of Signature of Funeral Service Licensee 7250 Washington RV any Elkridge FH mD21675 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Ap roximate Interval Between Onset and Death Immediate Cause (Final Physician 3 day disease or condition Joshnaum resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) death certificate be executed burial-t Due to (or as a consequence of) physician the burial Records, P.O. Box 68760 Physician/Medical as t IF FEMALE use If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 mont Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) ed by the a 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 🗌 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an autopsy page this certificate 2 No 1 □ Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3 No Hospital 1 Yes Inpatient Medical Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1-Natural 1 ☐ Yes 2 ☐ No 2 Accident within 24 hours after death To the Funeral Director: filled in by the 6 □ Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide the Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier completely and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 25 03,20,20130. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Redistrar's Baltimore MD Shan 31. Date filed (Month, Day, Year) State 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last)

Joseph William 2. Date of Death 3. Time of Death Saffran, Jr. Physician/ March 27 ay 2011 Year 9:20am M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death N/A **Examiner** 4b. City, Town, or Location of Death 1127 Bayard Street Baltimore City 5. Social Security Number 218–26–8791 Sex 1XXM 2□F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Funeral 9. Birthplace (State or Foreign 80 Months Days Hours Sept 2, 1930 Director MaryTand Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD N/A Baltimore City 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1127 Bayard Street 21223 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☐ Yes 2XXNo Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 X Widowed 4 Divorced or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Groundsman Cemetery Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Joseph William Saffran, Sr Mary A. Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christopher Saffran (Son) 1129 Bayard Street Baltimore, MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place) New Cathedral 3/30/2011 Baltimore, MD injury 4 ☐ Donation 5 ☐ Other (Specify) Cary L. Kaufman FUneral Home at MMP, Flkridge, MD 21. Signatore of Funeral Service Licenses L. Kaulman Washington 23a. Part 1. Enter the disease, or comblications that clusted the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or or diffior resulting in death)

a. Due to (or as a consequence of): Interval Between Onset and Death Pnysician/ 1004 Medical Due to (or as a consequence of) Examiner 0 Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an After this certificate has I page 2 autopsy performed 1 Yes 2 No the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗷 No ၉ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work?
1 Yes 2 No Accident Investigation 24 hours after death Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifie 🗲 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 9b. Signature and title 29d. Date signed (Month, Day, Year) Mar 28, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Schwartz

31. Date filed (Month, Day, Year)

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State

Registrar

DHMH 17 Rev 7/2009

ORIGINAL

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death Month 1552 **Physician** ugenc 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c., County of Death Examiner The Johns Hopkins Hospital **Baltimore City** If Under 1 Year | If Under 24 Hrs.

Months | Days | Hours | Min. 8. Date of Birth
Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex . Age (In yrs. last birthday) **Funeral** 7010 1 DM 2 F Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County show 1 Yes 2 No Ocean MP Director the Medical Examiner must be notified Worcester 28a-f 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code ō 21842 15A by Funeral Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner once. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Eugene ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10206 Bent Creek Rd. Oceancity MD 219421 20a. Method of Disposition

1 Burial 2 Cremation 3 Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State Tamaqua, PA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature Juneral Sinio Lice 22. Name and Address of Facility ray Home P. A. Die Fredhirton Pass Bruto MD : 23a. Patr. F 1x the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, o heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat ause (Final **Physician** disease or condition resulting in death) /Medical Due to or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or nighty that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed use as the burial-tran Due to (or as a consequence of): Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Fetal death 3 Ectopic pregnancy eral Director: After this certificate has been signed by the atter filled in by the funeral director, page 2 should be detached for in the past 12 months? Pregnant at time of death 5 Other (specify) 1 Yes 2 No P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I þ Division of Vital Records, No 3 Probably 4 Unknown 1 Tes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 2 🗌 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Hospital: Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other (Specify)} \) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this or 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 🗌 Yes 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical one) and manner stated 29b. Signature and title of certifier Date signed (Month, Day, Year) PES-000 01,2011 1160001 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 32. Registrar' Signature State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 29, 201^{Year} Rose 2:50 P M Santos Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Wilson Health Care Center Gaithersburg Montgomery Social Security Number 8. Date of Birth ___(Month, Day, Year) January 3, 1921 If Under 1 Year | If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 🔀 F Hours 080-30-2820 Puerto Rico Director 90 Usual Residence of Decedent items 23a or 28a-f show her must be notifled at within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Montgomery Gaithersburg 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 301 Russell Avenue 20877 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ıral", or iten I Examiner n 14. Race - American Indian. þ 1 Never Married 2 Married Maryland 21215-0036 1 ☑ Yes 2 ☐ No Specify: Puerto Rican Specify: White Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) perior. Page 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumation. Elementary/Seconday (0-12) College (1-4 or 5+) 12 Seamstress Clothing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Rosendo Santos Maria Garcia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Jones / Daughter 14110 Stanwood Terrace #202 Rockville, MD 20850 Baltimore, 20a Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Marche 31. cemetery, crematory or other place)
Montgomery
Crematorium, Inc 1 Durial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Bethesda, Maryland 21. Signature of Funeral Service Unenglee 22. Name and Address of Facility
Robert A. Pumphrey Funeral Home, Rockville, Inc
300 W. Montgomery Avenue Rockville, Maryland 20850 MO1607 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical r as a consequence of Examiner per tensue car Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Completed by Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day 1 Yes 2 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of certificate has autopsy performed Yes 2 death? isation! 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? Other: ျ 1 Tes 2 I No 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 IDOA 24 hours after death. Funeral Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Man er of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred ✓ Natural 5 Pending work' 1 Tes 2 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 04115 1 Li Robert Birschle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20/RUSSELLAVENUE

14. ROBERT BIRSCHBALLY MA GAITHERS SURG, MS 20877 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ $Ap^{Month}1$ 12:48 PM 2011 Alfred Smith, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Baltimore 1109 Rosedale Avenue Rosedale 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Hours West^{ry)}Virginia Months Marth 4 Day 1 9 2 1 234-28-7215 90 Yrs. **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Rosedale 1 Yes 2 No Baltimore Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ed other than "natural", or items 23a or event, the Medical Examiner must be with 1 Funeral 1109 Rosedale Avenue 21237 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Specify: Completed 3 Divorced 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) $\overset{\text{Elementary/Seconday (0-12)}}{12\,\text{t}\,h}$ College (1-4 or 5+) and Mental Hygiene. Mechanic Auto Be (unk) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit, Page 1 and 2 should be f Department of Heath and Menta Important: If item 27 is marked any injury or other traumatic ev once. 2 Ida Belcher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Maryland 21237 Sherida Barr /Granddaughter8436 Coco Road Rosedale, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Aproid ty Hill Mem Gar 5, 2011 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility aczorowski Funeral Home, P.A. 21. Signature of Funeral Service Licensee 201 Dundalk <u>Avenue Baltimore.</u> 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 Hospital or Attending Physician: The law requires that the death certificate 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform After this certificate 2 🗌 No Yes 2 No 1 Yes within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) . Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending ☐ Natural ☐ Accident work? 1 Yes 2 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide . Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 29d. Date signed (Month, Day, Year) ress of pokeon who completed cause of death (Item 23a) (Type, Print)
Jones, CRNP 2300 Dulaney Valley Road Timonium, Md. 30. Name and address Jackie 32. Registrar's gnature State APR 0 4 2011 Registrar

2:43pm

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH :00 A M 2011 Medical 4a. Facility Name (if not institution, give street and numbe Examiner 4b. City, Town, or Location of Death 4c. County of Death N/A COURS SE IIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Se (Month, Day) 4ar) 1 959 Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 🕌 Maryland Director 219-74-6693 Yrs. Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director N/A Baltimore Maryland 1X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21216 USA 1712 N. Warwick Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: rem 27 is marked other than "natural", other traumatic event, the Medical Exa Completed 3 → Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important If item 27 is marked other than any injury or other traumatic manages. Elementary/Seconday (0-12) College (1-4 or 5+) Nursing Homes **GNA** <u>12th grade</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Willar Dean Manning Dixon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
1712 N. Warwick Avenue Baltimore, MD 21216 Mary Williams /Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Western Star Cemeter Catonsville, Maryland 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 21. Signature of uneral Service License 22. Name and Address of Facility Chatman Harris Funeral Home 5240 Reisterstown Rd Baltimore, MD 21215 23a. Part . Enter the is se, or complications that caused of ock, or heart fail re. List only one cause on each line. se, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest mediate Cause (Final Onset and Death Physician/ ARCINOMA ESOPHAGUS disease or condition resulting in death) Medical Due to (or as a consequence of): ICTIVE PULMONARY **Examiner** Sequentially list conditions, Examine Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last ARDIOVASCULAR DISEASE ending physician and use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No for Pregnant at time of death Month Day Year detached g 🗌 Unknown g 🗌 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 certificate has autopsy performed Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 🗌 Yes 2 No Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 Natural 2 Accident 3 Suicide 5 Pendina 1 🗌 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and title of certifier and address of person who completed cause of death(them 23a) (Type, Print) BON SECOURS 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Tyeshawn Townse		- For State	State	of Maryla	and / [-	tment o			Mental H		20		10555
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Medical Examine	-	Tyeshawn Del			nd						Month March 20	Day Yea , 2011	r	1234 hrs
		4a. Facility Name (if not ins	stitution, give street and number)						ocation of Death		4c. County of			
		Johns Hopkins Ho						Baltim				11	N/A	
Funeral		5. Social Security Number	6. S	1	7. Age (I	n yrs. las	t birthday)	If Unde	r 1 Year Days	If Under 24Hrs Hours Mir		,	h(MM/DD/YYYY) 9. Birthplace (State	
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5-0036 led within 7 Hygiene. lother than	5	() 17. Father's Name (First, M	iddle Last	1		L			N/A	R Mother's Name	/First Middle	Maiden Surname)	IN/ A	
215.		Tyrone Barne								Kristen				
212 ould b d Meni s marl		19a. Informant's Name/Refa				-	19b. Mailing	Address				mber, City or Town	n, State,	Zip Code)
MD 12 shouth and 127 is 727 is rumati		Lucille Townsen	d - Go	eat Grand	mothe		3703	1/2	Colur	nbus Dri	ive Bali	timore, N	ary!	land 21215
F. Head		20a. Method of Disposition	ontion 2	□ Romoval fr	om Stata		ace of Disposematory or other		e of ceme	etery,	Date	20c. Location -	City or T	Town, State
Pages Pages nent of unt: 1	1 PBurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify: King Memorial Park 3/28/2011 Woodlawn,									m, l	Maryland			
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiens (Department of Health and Mental Hygien dother than "mattern", or items 23a or 28a-f abo injury or other traumatic event, the Medical Examiner must be notified at once. To Re Commission by Ermonal Director		21. Sign dure of Funeral Se	rvice Licar	ee			22. N	lame and A	Address	of Facility Char	tman-Harr	is Funeral e, Maryl <i>a</i> n	Home	9
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30x 68760, death certificate bo attending physic for use as the bur		F FEMALE: 3b. Was decedent pregnan	t in the	23c. If yes,	outcome o		U = 1 P	CI m				23d. Date of		
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Division of Vital Records, tall or Attending Physician: The law require and rest death. The law require and preceder. After this certificate has been sigled in by the funeral director, page 2 should by artification: To Be Commisted.	<u></u>										perfo 1 ✓ Yes		eath? ✔ Yes	2 No
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Division Division Hospital or Attent 24 hours after death Funeral Director: stely filled in by the		4 Homicide	og Physici					red at the t	ime date	and place and		se(s) and manner		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the burithed that the completely filled in by the funeral director, page 2 should be detached for use as the burithed that the physician Medical Certification: To Be Completed by Physician Medical	3	-			of examina							and place, and du		
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			O.C.M.E. March 21, 2011											
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1 1				Chief Medic				n Street	t, Baltin	nore, MD 21	201			
State Registra		31. Date filed (Month, Day,)	ear)	32. Re	egistrar's S	oignature /								

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 031PM Marion Elizabeth Talbott MARCH 3 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death TIMORE Social Security Number If Under 24 Hrs 7. Age (In vrs. last birthdav) If Unde 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XX Hours (Month, Day, Virginia **Director** 81 1929 220-20-5926 Usual Residence of Decedent 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Howard Elkridge 1 Yes X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6391 Rowenberry Ct Apt. 109 21075 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian þ 1 Never Married 2 Married 1 Yes 2 No If Yes, Give X Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: Completed 3 Widowed 4 X Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) should be filed within 72 hand Mental Hygiene.
7 is marked other than "r Pimlico Racetrack Elementary/Seconday (0-12) College (1-4 or 5+) <u>Operator</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Arthur Byron Selph Anna Elizabeth Baber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health a Important: If item 27 is Neal Talbott/ Son 4613 Saladana Dr. Fort Worth, Texas, 76133 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 KBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Meadowridge Memorial | April 2,2011 Elkridge, Maryland 22. Name and Address of Facilitary L. Kaufman Funeral Home, Inc. 21. Signature of Funeral Service Licenses 7250 Washington Blvd., Elkridge, Maryland, 21075 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Pregnant at time of death 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy performed? Yes 2 No 2 No 1 Yes 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes 2 No မြ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 2 No 1 Yes Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I _ Certifying Nurse Practioners To this best of in through does wise to count did this time, data and plant, and due to the cause (a) and manner as states 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 900 JONATHAN CATON 81. Date filed (Month, Day, Year) 32. Registrar's APR 04 Registrar

DHMH 17 Rev 7/2009

MARION

TALBOT

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien Certificate of Death Reg. No. 1 Decedent's Name (First Middle Last) 2. Date of Death 3. Time of Death Physician/ Month 12:55 THOMAS March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Funeral 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 D F Months (Month, Day, Year) Sept 8, 194 212-38-9348 Country VIRGINIA Director Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at 10b. County 10a, State 10c. City, Town or Location 10d Inside City Limits Director MO FREDERICK FLEOGRICIE 1 ✓ Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral FIFTH EAST 21701 US 217 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces Black White, etc. þ 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Hygiene. other than "natural", 3 Widowed 4 Divorced Specify: Completed Year or Dates traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) OF life, DO NOT use retired) STATE Elementary/Seconday (0-12) PAINTER 0 TH MARY and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) Department of Health and Mental H Important: If item 27 is marked Any injury or other 18. Mother's Name (First, Middle, Maiden Surname) ည LitomAS LYNN ELIZABETH H 11-1-19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) HARRIS ALYS (SISTER) FREDERICK MD. 204 CENTER ST. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory Burial 2 ☐ Cremation 3 ☐ Removal from State or other place FRED GRUM Com 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility GARY L. ROLLINS FUNCEACHME 21. Signature of Funeral Service Licensee Jary X. SOUTH ST FREDERICK MARY ILANO ZITOL 011 110 WEST 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ hepatoma disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Irrhosis Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): hepatitis Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and that initiated events resulting in death) Last thrombosis Physician/Medical VEAN Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death as been signed by the 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by differentiated netastatic 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗡 Unknown in addition 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed page hyponatemia hypertensia certificate 1 ☐ Yes 2 No 25. Was ase referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital 1 ☐ Yes 2 XNo မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No after death Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signatur 29c. License number D 65 5 0 6 1 of certifie March Completed cause of death (Item 23a) (Type, Print)
AGY. MD 300 WEST NINTH STREET, FREDERICK, MD 21701 NXGY. AUBRIE 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State
Registrar Certificate of Death 2. Date of Death 3. Time of Death Physician/ March 31 Day 2011 Year 3:40 Mary Ruth Vencill Thompson Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Shady Grove Adventist Hospital Rockville Montgomery If Under 1 Year If Under 24 Hrs. 8. Date of Birth May 1, 1924 **Funeral** Age (In yrs. last birthday) 9. Birthplace (State or Foreign Days Hours Min. Virginia **Director** 230-18-6865 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Maryland Montgomery Germantown 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 11309 Halethorpe Terrace 20876 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married þ 21215-0036 1 ☐ Yes 2 🔀 No Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Pharmacy Clerk Drug Fair Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Robert Vencill Susie Buchanan 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Susan E. Thompson/Daughter 11309 Halethorpe Terrace, Germantown, Maryland 20876 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Cemetery, crematory or other place)
Montgomery
Crematorium, Inc. April 3, 2011 20c. Location - City or Town, State 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) Bethesda, Maryland 21. Signature of Funeral Service Licensee Robert Adres Pulliphrey Funeral Home/Rockville, Inc. M01360 300 West Montgomery Avenue, Rockville, Maryland 20850-2805 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Priysician/ 500515 disease or condition resulting in death) 40415 Medical Due to (or s a consequence of): Examiner heumonia day 5 Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Year Pregnant at time of death Day been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part t. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of cate has autopsy performed? death? 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🖼 No Other: ၉ 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 Z ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 🛭 Natural 5 Pending work 1 Yes 2 🗌 No after death Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the I within 2 3 Pertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title certifier 29c. License number 29d. Date signed (Month, Day, Year) 6255 MI) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MCHeil 9901 Patsu MD Medical Center Dr. Rockille, MU 31. Date filed (Month, Day, Year) 32. State parle Registrar

Division of Vital Records, P.O. Box 68760

1105

3

MARCH

HOM PSON

31. Date filed (Month; Day, Year) State Registrar

Melissa Brassell, MD

29b. Signature and title of certifier

30. Name and address of person who completed dause of death (Item 23a)

32. Registrar's Signature

Assistant Medical Examiner

29c. License number

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 23, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 25° Varasteh March 20 T Tourandokht 8:15 PM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Bethesda Health and Rehabilitation Center <u>Bethesda</u> Montgomery If Under 1 Year | If Under 24 Hrs Months | Days | Hours | Min. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🕱 F Months October 26, Country) 91 Director 457-59-1967 1919 |Iran Usual Residence of Decedent 3a or 28a-f show be notified at 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director 1 X Yes 2 No Ontario Canada Aurora # 0 and 2 should be filed within 72 nouses and 2 should be filed within 72 nouses and 4 of Health and Mental Hygiene.
If item 27 is marked other than "natural", or items 23a or an in the Medical Examiner must be resent. 10e. Street and Number 10f Zin Code 10g. Citizen of What Country? Funeral 96 Deerglen Terrace L4G 6Y3 United States Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: 3 X Widowed 4 Divorced Completed Year or Dates. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Yasdanpanah Morteza Farnaz (not available) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Afsi Varasteh/ Granddaughter 20 Burkebrooke Place #419, Toronto, ON, Canada M5G OAl permit. Page 1 and 2 Department of Healtl Important: If item 2: injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Montgomery Crematorium Inc. April 2, 2011 Bethesda, Maryland M01596 Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave. Bethesda, Maryland 20814 21. Signature of Funeral Service Licensee Part 1. En 4r the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Obstructive Jaundice years Medical Due to (or as a consequence of Examiner Cancer Pancreas years Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed the bunial-transi that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical for use as IE FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No 5 Other (specify) Pregnant at time of death Month Dav Year 4 ☐ Pregnant ☐ Unknown g Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Clostridium Difficle Colitis, Cholangitis, Sepsis, 1 ☐ Yes 2 🏋 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Alzheimer's Dementia page 2 autopsy Hospital or Attending Physician: The performed? certificate 2 No 2 X No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 X Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 🛛 No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work' 1 Yes 2 No Investigation 6 Could not be Accident filled in by the 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital within 24 hours To the Funeral [Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 28, 2011 17656 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

Tipaporn Woodward,

31. Date filed (Month, Day, Year)

APR 0 4 2011

M.D.

32. Registrar's Signature

Box 68760

P.O.

Records,

Division of Vital

parke

7830 Old Georgetwon Road Cl5, Bethesda, Maryland 20814

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Apronth1 ^{Day} 2011 Year Elizabeth Wilson 1 05 р Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** N/A1939 W. Baltimore Street Baltimore . Age (In yrs. last birthday) 76 yrs Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex **Funeral** (Month Day, Min 157-26-3872 1 M 2 TXF Hours 1934 Director Dec 10b. County N/A 28a-f shov 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits notified at Director MD Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? ms 23a or Funeral Baltimore Street 21223 USA 1939 W. ural", or items Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

Yes 2 K No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify:Black If Yes, Give Year or Dates 1 ☐ Yes 2 No Specify: Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the I Private Home Housekeeper N/ABe 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Martha Lee Dicks 2 George Stuckey 19a. Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 527 W. Fairmont St. Balto., MD 21223 Lenoras Wilson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date King Memorial PK 1 X Burial 2 Cremation 3 Removal from State Woodlawn, MD 4/8/11 4 ☐ Donation 5 ☐ Other (Specify) permit. 22. Name and Address of Facility Beverly D Cromartie F/S 2700 Edmondson Ave. Balto., MD 21223 Signature of Funeral Service Licenses Part 1. Enter the disease, or complications that caused the path. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each liver the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death 5 Other (specify) 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>م</u> Records, 1 Yes 2 No 3 Probably 4 Unknown Completed plnous 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has l page 2 s autopsy performed 1 Yes 2 No Yes 2 No 25. Was case referred to medical Division of Vital Be the funeral director, 26. Place of Death (Check only one) examiner's Hospital: Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 1 ☐ Yes 2 ☑ No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred (Month, Day, Year) injury 1 Natural 5 Pending Accident Investigation 6 Could not be within 24 hours after de To the Funeral Directo completed filled in by the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a. Certifier 1 🔛 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar KANENIN.

APR 04

31. Date filed (Month, Day, Year,

WERNITT

2835

32. Registrar's Signature

Smith

saltemore

Sute 203

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ March 24. 2:45 A.M Wilkins Margaret Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Anne Arundel Marley Neck Nursing & Rehab. Ctr. Glen Burnie If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 🛛 F 877271935 Pennsylvania Director 214-56-7145 75 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director Glen Burnie 1 🗆 Yes 2 🖺 No Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 21060 10g. Citizen of What Country? items 23a or 7647 Spencer Road Funeral United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ ō 1 Never Married 2 Married Yes 3 Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give "natural", 3 Widowed 4 XXVvorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker and Mental Hygie is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) 2 Unknown Yota Weller Leahey traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 500 Red Land CourtSuite 204, Owings Mills,MAryland 2111 Paula Tiberio/Guardian 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Meadowridge Memorial | March 292100 Elkridge, MAryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gary L. KAufman Funeral Home, Inc 7250 Washington Blvd. Elkridge, Maryland, 21075 23a. Part 1. Inter the disease, or commications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one cause on each line. and was culab 18 come nterval Between Onset and Death Immediate Cause (Final Physician/ Sclevolco disease or condition Medical resulting in death) as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 attending ph for use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No 9 Unknown 9 Unknown been signed by should be detac Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Onknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has 2 No Yes 2 4 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Division of Vital 26. Place of Death (Check only one) Hospital Other: ည 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Hospital 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of certifier 30641 anne Name and address of person who completed cause of death (Item 23a) (Type, Print) (GMEIL SCHOPEUL) 201-108 BACK

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Back River Meck Road Balhouse Mayland 21221

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day WEAT Physician/ FLWOOD LERDY 7:45,5 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Howard County General Hospital Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 03-02-1929 1.XM 2 - F Pennsylvania Director 193-24-4116 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director "natural", or items 23a or 28a-f s edical Examiner must be notified 1 Yes 2 X No MD Columbia Howard 10e. Street and Number 10g. Citizen of What Country? Funeral 21045 8610 Snowden River Pky - 413 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces? 1 Never Married 2 X Married Completed by 1 X Yes If Yes, Give 2 No 1 Yes 2 X No Specify: 3 🗌 Widowed 4 🔲 Divorced White Year or Dates marked other than "natu matic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. Engineer AT & T Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Russell E. Wertz Olive P. Slippy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. 8610 Snowden River Pky - 413, Columbia, MD 21045 Donna Wertz - wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 😰 Burial 2 🗆 Cremation 3 🗆 Removal from State Meadowridge Mem Park | 04-05-2011 | Elkridge, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Ligen 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, Inc, 7250 Wash. Blvd., Elkridge, MD 21075 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. PIVEUMONA Onset and Death Immediate Cause (Final Physician/ disease or condition - Medical resulting in death) Due to (or as a consequence of): **Examiner** DISEASE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or linjury that initiated events B1417 Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Month Year 4 ☐ Pregnant at time of death 9 ☐ Unknown Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 25. Was case referred to medical 26. Place of Death (Check only one) To Be examiner? Hospital Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28b. Time of 28d. Describe how injury occurred 5 Pending injury work 1 Yes 2 No 2 Accident
3 Suicide Investigation Director: 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 \square Homicide determined within 24 hours Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

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To th Within To th Comp		29b. Signature and		1	- 1/1	Λ		29c. License	e number			29d. Dat	e signed (Mo	nth, Da	y, Year)
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11-02238

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	1- For State Certificate of Death	11 10565
Physician/ edical Examiner	1. Decedent's Name (First, Middle, Last) 1. Decedent's Name (First, Middle, Last) Month Day Ye	3. Time of Death 1209 hrs
edical Examiner	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 19 North Locust Street Apt. 2 4c. County Hagerstown Washin	
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYY	Y) 9. Birthplace (State or
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ath with the Maryland items 23s or 28s-f show ust be notified at once.	10e. Street and Number 1235 North Augusta Ave 10f. Zip Code 21229	Vhat Country? USA
ap sell T	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Rac White White 15. Was Decedent Ever in U.S. 16. Yes 2 No 17. Yes 2 No 17. Yes 2 No 18. Yes 2 No 18. Puerto Rican, etc.) 19. Yes 2 No 19. Yes 2 No 10. Yes 2 No 10. Yes 2 No 10. Yes 2 No 10. Yes 2 No 11. Yes 2 No 11. Yes 2 No 12. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 19. Yes 2 No 10. Ye	ce - American Indian, Black, lite, etc. White
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Baltimore, permit. Pages I a Department of He Important: If its injury or other th	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Simplicity Cre ThomasAllenPA 7090 Ridge Rd 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest, shock, or respiratory arrest.	
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F Vital Physician: r this certifical director, To Be (25. Was case referred to medical examiner? 1 V Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other 4 Nursing Home 5 Residence 6	
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Division o To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune Medical Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Nu or Town, State) 19 1 Apt. 2 Hagers	mber or Rural Route Number, Ci N. Locust St. town, Washingto
To the Host within 24 ho To the Func completely f		nner as stated. Md.
To vit	29b. Signature and title of certifier 29c. License number O.C.M.E. March 23	igned (Month, Day, Year) 3, 2011
off	30. Name and address of person who completed cause of death (Item 23a) Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State Registra	6 13 Li 11 /1 / (111 1 1 / // - 1) All 1 / All	

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

ennis Levern V	1	- For State	nd / Department of <i>Certificate of</i>	Health and Mental Death	Hygiene Reg. N	2011	10566
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MOCE, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland ret of Health and Mental Hygiene. unt: If item 27 is marked other than "natural", or items 23a or 28a-5 she is other traumatic event, the <u>Medical Examiner must be notified at once</u>	Completed by	15. Decedent's Education (Specify only highest grade Elementary/Secondary (0-12) College (1-4)	4 or 5+) during m	it's Usual Occupation (Give kind ost of working life. DO NOT use	e retired)	b. Kind of Business/Indu	1
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Division of Notice to the Hospital or Attending Phewithin 24 hours after death within 24 hours after death. To the Funeral Director: After to completely filled in by the funeral	Certification:	Suicide determined (Specify)	e of Injury - At home, farm, stre	eet, factory, office building, etc.	28f. Location (Stre or Town, Stat	eet and Number or Rural e)	Route Number, City
Hospita 24 hours Funera		4 Homicide 29a. Certifier (Check only) Certifying Physician: To the bes	t of my knowledge, death occu	urred at the time, date and place	e, and due to the cause(s	s) and manner as stated	cause(s)
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of and manner standard and manner standard and title of certifier	tated.	29c. License number		29d. Date signed (Month	
		AIII	8/1)	O.C.M.E.		March 30, 2011	
KV		30 Name and address of person who completed cause	e of death (Item 23a) ledical Examiner 11	1 Penn Street, Baltimor	e. MD 21201		
	tate			factal and	-,		
Ponis		0 4 0044	The same of the same	alter		al 4 2 5	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Dinette Wallace 0320 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltinose n/a SECOURS Hospital Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 F Country) MD Hours 0890471985 212-90-5309 45 **Director** Usual Residence of Decedent show 10b. County 10d. Inside City Limits ms 23a or 28a-f sho must be notified at 10c. City, Town or Location filed within 72 hours after death with the Maryland Director MD n/a Baltimore 1 XYes 2 No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 21216 4505 Fairview Avenue Apt. D "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Completed by 1 X Never Married 2 ☐ Married 1 Yes : 2 XNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black 3 Divorced 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturaly injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Carlo Glass Production Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joyce Ann Riley Harvey Lamont Wallace 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2554 Cecil Ave Baltimore, MD 21218 Antoinette Henderson- Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Baltimore Crematory 4.6.2011 Baltimore, MD 21. Signature Funeral Service John L. Williams Funeral Directors, P.A. 4517 Park Hgts Ave Baltimore, MD 21215 23a. Paryl . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed Drenmonia and for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last s been signed by the attending physician should be detached for וופת ביי Physician/Medical HIVDivision of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy funeral director, page 2 2 🗌 No 25. Was case referred to medical examiner?

1
Yes
2 Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manger of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate; 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 166108 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 000

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year) APR 0 4 2011

Registrar's Signat

Please Type or Print in Black in the link. Ensure All Copies Are Legible.

Amend Item 242 at the of Waryland Penalth and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH2011 2:50P Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death GENESIS HEALTH CARE CENTER PLATA CHARLES LAIf Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 482 18-24 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2🗶 F NOV. DZY, Yerr922 IOWZ 88 Director -18-2442 Usual Residence of Decedent rral", or items 23a or 28a-f shov Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or post. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD CHARLES LA PLATA 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral NUMBER 1 MAGNOLIA DRIVE 20646 U.S. Α. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Comporced Specify:WHITE Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) MOTEL WORKER STARDUST MOTEL Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
JESSIE P. MEALUS ပ္ OTTO VERNON WOODS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20659$ PATRICK SHYMANSKY/FRIEND 28485 THOMPSON CORNER RD.MECHANICSVILLE, MD 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other) 20c. Location - City or Town, State MARCH 1 ☐ Burial 2 XCremation 3 ☐ Removal from State 25, 2011 ALEXANDRIA, VA METRO.CREMATORY 4 Donation 5 Other (Specify) Signature of Funeral Service Licensee 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P.A. M00641 5635 WASHINGTON AVE., LA PLATA, MD 20646 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. disease or condition mone Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any mading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) signed by the attending physician and de detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last by Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes Completed 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy performed^a Yes 2X No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ည 1 Tyes 2 🗆 No Other: 1 Inpatient 2 I 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 29a. Certifier 🛮 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed/(Month, Day, Year) ered cause of death (Item 23a) (Type, Print) 30. Name and address of person who 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Registrar

31. Date filed (Month, Day,

Year)

Registrar

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Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 4:45 March Medical <u>Robert Ernest Bever</u> 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington 304 Kingswood Terrac<u>e</u> <u>Hagerstown</u> Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min. (Month, Day, Year, Director . Virginia 232-54-4656 March 1. 1936 West Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD Washington <u>Hagerstown</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 304 Kingswood Terrace 21742 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. "natural", or þ 1 Never Married 2 X Married 1 ☐ Yes 2 🔀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 😾 No Specify: Completed Specify: 3 Widowed 4 Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 6+ Pharmacist Pharmacy / Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o any injury or other traumatic eve ည Robert Theodore Beyer Mildred Louise Tyson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Victoria A. Beyer / Wife</u> 20a. Method of Disposition 304 Kingswood Terrace, Hagerstown, MD 21742

20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/21/2011 <u>Davis. West Virginia</u> <u>Davis Cemeterv</u> Signature of Funeral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ DRONARY disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions. Examine if any Letting to immediate cause. Enter Underlying Cause (Disease or iinjury Due to lor as a consequence of and I-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): anding physician use as the burial-Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown icate has been siç r, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of autopsy performed? Yes 2 No death?
1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) 24 No Other: 1 \square Yes 4 Nursing Home Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 1 Natural 5 Pendina 1 ☐ Yes 2 ☐ No Accident Investigation 2 ☐ Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe DC055994 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) VH-20 mo medical Campus and -isa K Higg 21124 31. Date filed (Month, Day, Year)

Registrar DHMH 17 Rev 7/2009

State

Box 68760

P.O.

Division of Vital

			For State State Registrar	of Maryland		artment <i>tificate</i>			and M		giene Reg. No.		10572	
			Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death	
	Physici /Medio		ROSA LEE BOYD							March	16		8:15 A M	
	Examin	er	4a. Facility Name (If not institution, give street and r	iumber)		**		Location of	of Death			4c. County of Death Prince George's		
			14911 River Chase Court 5. Social Security Number 6. Sex	7. Age (In yrs. las	t hirthday)	Bow:		If Under:	24 Hrs.	8. Date of Birtl				
10	Funeral Director		237-38-4844	84	Yrs.	Months	Days	Hours	Min.	(Month, Da)	v, Year)	1926 Pir	nplace (State or Foreign untry) netown, NC	
			Usual Residence of Decedent											
	urylan show	_	10a. State 10b. County		Town or Lo	cation						0.0	10d. Inside City Limits 1	
	Ba-f s	cto	MD Prince George'	s Land	dover	1					10- Citi	zen of What Co		
	with ti	급	10e. Street and Number 7731 Merrick Lane			10f. Zip	785				rog. Citi.	USA	unity :	
	eath	erai		ecedent Ever in U.S.	13.			spanic Ori	gin? (Sp	ecify Yes or No- Rican, etc.)		14. Race - Ame		
36	n 72 hours after death with the Maryland "natural", or items 23a or 28a-f show cdical Examinat must be notified at	Completed by Funeral Director	Armed	Forces? s 2⊠No Give		fYes, spec 1 ☐ Yes 2		Specify:		Rican, etc.)		Specify: B1		
21215-0036	2 hou	ted !	15. Decedent's Education		16a. Dece	dent's Usua	i Occupa	tion	A = 6= d		16b. Ki	nd of Business/	Industry	
215	hin 73	pie	(Specify only highest grade complete Elementary/Secondary (0-12) College	d) (1-4or 5+)	life.	kind of wor DO NOT us	e retired,) -	t or work	ing	_			
	ed wit	Con	11th		N.	urses	Aid					rivate		
nd	be file	Be	17. Father's Name (First, Middle, Last) George A. King							e (First, Middle, 11 Lawre		Sumame)		
Z	hould d Mer narke natic	2	19a. Informant's Name/Relationship (Type, Print)		19h Mailir	na Address	/Street a			al Route Numbe		r Town, State, 2	Zip Code)	
Maryland	d 2 si th an t7 is r traur		Brenda Jiggetts - Daug							, Bowie				
	s 1 an f Heal fem 2	1 16	20a. Method of Disposition	20b. Plac	ce of Dispo	sition (Nam	ne of		_	Date		cation - City or		
9	Pages nent of nt: If It iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal fro 1 ☑ Donation 5 ☐ Other (Specify)	m State Whitf	ield&	Whitle	y Cen	etery	03/	25/2011	Wasl	nington	, NC	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natur any injury or other traumatic event, the Medical Once.		Whitfield & Whitley Cemetery 03/25/2011 Washington, 21. Signature of Facility Johnson & Jenkins Fune 716 Kennedy Street, NW, Washington, DC										HET I STANDARD BY DESCRIPTION	
	1330		23a. Part1. Enter the disease, or complications that	t caused the death.		-						- NATE	Approximate Interval Between	
M	Physician		regulting in death)	AL FAILUR		CUTE	KIDN	EY FA	AILU	RE			Onset and Death 5 Months	
	/Medical Examiner		DIABETES MELLITUS										32 Years	
		er	Sequentially list conditions, if any, leading to immediate	to (or as a conseque										
	uted	Examiner	cause. Enter Underlying	ERTENSION									Unknown	
,092	ate be executed hysician and he burial-transit	ical Exa		to (or as a conseque	nce of):									
687	certificate iding physise as the		d											
Box	death e atter id for u	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 X No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify)									23d. Date of de Month	livery Day Year	
P.0	requires that the de een signed by the nould be detached	Phy	9 Unknown Part II. Other significant conditions contributing to	death but not result	ing in the u	nderlyina c	ause dive	en in Part I	1.	23e. Did t	obacco i	use contribute to	the cause of death?	
ds,	Se G	d by	ANEMIA OF CHRONIC DI		ang mano a		acco g			1 🗆	Yes 2	K∏No 3∏Pi	robably 4 Unknown	
Ö	> 0 %	ete							***	24a. Was	an	24b. Were at	utopsy findings available	
Records,	e la has	ompleted		<u>.</u>						autor perfo		prior to death?	completion of cause of	
Vital	ilcian: Th certificate rector, pag	0	25. Was case referred to medical					26. Place	e of Dea	th (Check only o		1310	220110	
f Vi	d is	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital:	□Inpatient 2□El	R/Outpatie	nt 3 DC	Othe	er: 4 🗆 Ni	ursing H	ome 5 Resi	dence	6 ₩Other (Spe	Daughter's	
n of		on:	27. Manner of Death 1 ☑ Natural 5 ☐ Pending (M	te of Injury 2 onth, Day Year)	8b. Time o		Bc. Injun Worl			28d. Describe	how inju	ry occurred	RELETE	
Sio	Attending r death. sctor: After by the fune	cati	2 Accident investigation	and the same of the same		M	_	Yes 2	No	28f Location /	Stroot at	nd Number or R	ural Route Number,	
Division	spital or At ours after o teral Direc filled ir by	ertification;	determined 280, Pic	ace of Injury - At hom ilding, etc. (Specify)	ie, iarm, si	reet, factory	у, опісе			City or To			ara riodio riambor,	
	To the Hospital or Attendi within 24 hours after death To the Funeral Director: A completely filled in by the fo	edical C	29a. Certifier (Check only one) 152 Certifying Physician: To the and m	the best of my knowled basis of examination	ledge, deat on and/or in	h occurred vestigation	at the tin , in my o	ne, date ar pinion, dea	nd place ath occu	, and due to the rred at the time,	cause(s date and) and manner a d place, and du	s stated. e to the cause(s)	
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of confider					e number				ite signed (Mon	3.1	
	, 0					D	68	693	>		3	118121	011	
	2		30. Name and address of person who completed c	ause of death (Item 2	23а) (Туре,	Print)		C- •	h c /	00 4	on c 1	ic Ma	21/101	
- <)	of i	Courtney Milne-Krohn, M	D, II6 De Regist <u>rar's Signa</u> tu		High	way,	Sul	Le 4	Ann	apoi	La, Elu		
	Sta Regist			b. pa										
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DHMH 17 Rev 1/2001

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MARCH

BROADWATER

Records, P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#11perFH, G915, 5/16/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Kenneth March 10°, 201 far **Physician** Anthony Brown 7:15pm /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Locbury Court Montgomery

9. Birthplace (State or Foreign Country) Germantown 8. Date of Birth (Month, Day, Year) 3 / 0 9 / 1 9 4 8 Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours 1⊠M 2□F 137-38-9618 63 Bahamas Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County show ns 23a or 28a-f shov must be notified at 1 ☐ Yes 2 No MD Montgomery Germantown Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Pages 1 and 2 should be filed within 72 hours after death with 1 nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 2 ry or other traumatic event, the Medical Examiner must be n 13f Locbury Court 20874 IISA Funeral 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. Baltimore, Maryland 21215-0036
permit. Pages 1 and 2 should be filed within 72 hours after d
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or iten
any Injury or other traumatic event, the Medical Examiner.
once. 1X Yes 2 ☐ If Yes, Give Year or Dates: 2□No 1966 + Mever Married 2 Married Black 1 ☐ Yes 2 No Completed by 3 ☐ Widowed 4 X Divorced 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) Food Service Director Food Service 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Joseph Brown Estelle Shockley ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 13F Locbury Court Germantown, Md. 20874 Sherrie Bonaparte/Companion 20b. Place of Disposition (Name of William C. Doyle Memorial Cemetery Date 20c. Location - City or Town, State 20a Method of Disposition 3/17/2011 1 X Burial 2 ☐ Cremation 3 X Removal from State 5 ☐ Other (Specify) Wrightstown, N.J. 4 Donation Funeral Service Cicensee PHYTTETP ADDEST TOWALDI FUNERAL SERVICE, P.A. 21. Signatur 9241 Columbia Blvd.Silver Spring, Md20910 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Metastatic liver cancer Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Cause (Disease or injury Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and is the burial-tranthat initiated events resulting in death) Last Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, Physician/Medical aftending p 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 4 Pregnant at time of death Month Dav Year in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Tes 2 No 3 Probably 4X Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1□ Yes 2🔽 No 25. Was case referred to medical examiner? 26. Place of Death Check onl one Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 1 ☐ Yes 2x No Certification: To this 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury 27. Manner of Death 28c. Injury at Work? (Month, Day Year) 1 X Natural 5 ☐ Pending investigation within 24 hours after deau...
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 ☐ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier M035046 March 11,2011 4+

DHMH 17 Rev 1/2001

State

Registrar

3800 Reservoir Road Washington, D.C.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

82. Registrar's Signature

Aiwu Ruth He M.D.

MAR 21 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra MED#23a(a-d)perMD, 3/22/11; BMW, McCo Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month 5:55 P M March 11. 2011 James Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Arcola Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, 5. Social Security Number . Sex 1 X M 2 ☐ F 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Months Director 578-52-2663 70 Unknown 1940 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County 28a-f show Exeminer must be notified at 1 ☐ Yes 2 X No Director Maryland Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6 23a 10720 Georgia Avenue 20902 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Jo. 1 □Yes 2 No Specify: Black Completed by 3 ☐ Widowed 4 ☐ Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) 12 College (1-4or 5+) unknown unknown 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be a ment of Health and Mental Ith and Mental 27 is marked of traumatic eve unknown unknown 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Davis, Guardian Health is 401 Hungerford Drive 2nd Floor, Rockville, MD 20850 Injury or other D partment of Heal Important: If item 2 any Injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) <u>Fort Lincoln Crematory 3/21/2011 | Brentwood, Maryland</u> 22. Name and Address of Facility Simple Tribute 21. Signature of Funeral Service Licensee M01102 unh kave 1040 Rockville Pike. Rockville. Maryland 20852 23a. Pert1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. **Nephrotic Syndrome** Immediate Cause (Final **Physician** monceris disease or condition resulting in death) /Medical Due to (or as a consequence of Examiner Renal Failure months Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Hyperetension vears Due to (or as a consequence of): Division of Vital Records. P.O. Box 68760. Physician/Medical Anemia years IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☑ No 23d. Date of delivery 3

Ectopic pregnancy Day 5 ☐ Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Medical Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide e Funeral 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D50987 3-17-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAWA 1500 Forest glen Rd silver spring mo Altheo

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 21 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene

			1 - State of Maryland /	Certificate of L		, 0	ne . No.	
ı	Physicia Medi		1. Decedent's Name (First, Middle, Last) Kathleen Bridy			2. Date of Death Month March 14	Day 20 Van	3. Time of Seath 6
	Examir Funeral Director		4a. Facility Name (if not institution, give street and number) Suburban Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last bir. 215–46–2854 1	Bethe	r Location of Death esda If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye) 02/04/19	ar) Cot	nery hplace (State or Foreign
	And the second	Director	Usual Residence of Decedent 10a. State 10b. County 10c. City, Tow MD Montgomery Che			102/04/19	18 IWasi	10d. Inside City Limits 1 ₺ Yes 2 □ No
	with the Ns 23a or 29	Funeral Dir	10e. Street and Number 8100 Connecticut Avenue Apt. 100	10f. Zip Code 20815		10g	J. Citizen of What Co United St	untry?
9003	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any figury or other traumatic event, the Medical Examiner must be notified at once.	ρ	11. Marital Status 1 □ Never Married 2 □ Married 3 ☒ Widowed 4 □ Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 ☒ No If Yes, Give Year or Dates.	13. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🌠 No	Specify:	ecify Yes or No- Rican, etc.)	14. Race - Amer Black, White Specify: Whit	e, etc.
Maryland 21215-0036	within 72 ho /giene. ner than "na t, the Medic	e Completed	16	a. Decedent's Usual Occup (Give kind of work done c life. DO NOT use retired) Homemaker	ation during most of work	ing	b. Kind of Business I Own Home	Industry
ryland	uld be filed I Mental Hy narked otl natic even	To Be	17. Father's Name (First, Middle, Last) John Joseph Keehan		18. Mother's Nam Delia (e (First, Middle, Maid Greelish	den Surname)	
e, Mai	and 2 sho Health and em 27 is r		Alice Dillon / Daughter 1	b. Mailing Address (Street & 9351 Frencht	on Place	Montgomer	y Village	, MD 20886
Baltimore,	nit. Page 1 artment of ortant; If it injury or o		1 Burial 2 ☐ Cremation 3 ☐ Removal from State cemete.	of Disposition (Name of ery, crematory or other place of Heaven Ce	e) met 3/19	9/2011 Si	Llver Spri	ng, MD
Ва	Department of the control of the con		23a. Part 1. Enter the disease, or complications that caused the death. Do r	22. Name and Address 5130 Wisco	nsin Ave.	NW Washi		20016
~	h sician/ Medical		shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Congestive Hear a. Due to (or as a consequence of the	rt Failure	g, such as caldiac C	or respiratory arrest,		Approximate Interval Between Onset and Death Week
-	Examiner	ner	Sequentially list conditions, if any, leading to immediate b. Aortic Stenosis	s				15 Years
	e executed cian and ourial-transit	Aedical Examiner	cause. Enter Underlying Cause (Disease or iniqury that initiated events resulting in death) Last c. Due to (or as a consequence of					
Box 68/60	To the Hospital or Attending Physician; The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-yansit.	< ∣	d	h 3	у		23d. Date of deli	very Day Year
as, r.o.	quires that then signed by build be detac	ρ	Part II. Other significant conditions contributing to death but not resulting in	in the underlying cause give	en in Part I.		co use contribute to	the cause of death?
records,	r: The law rei icate has be r, page 2 sho	Completed				24a. Was an autopsy performed	prior to co	opsy findings available ompletion of cause of
Alfa	hysiciar nis certif I directo	To Be	25. Was case referred to medical examiner? 1 Yes 2 No 1 Inpatient 2 ER/Ou	Tout-	r: 4 Nursing Ho		e 6 ☐ Other (Specif	·v)
NISION OF	ttending P death. tor: After tl the funera	Certificate:	1 ☑ Natural 5 □ Pending (Month, Day, Year) ir 2 □ Accident Investigation 3 □ Suicide 6 □ Could not be		at } Yes 2 \Bo	28d. Describe how in	njury occurred	
	spital or Ai ours after eral Direc filled in by		4 Homicide determined 28e. Place of Injury - At home, far building, etc. (Specify) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, c			City or Town, Sta	_	
	o the Hos ithin 24 h o the Fun ompleted	Medical	(Check 2	or investigation, in my oninior	n, death occurred at time, date and place	the time, date and place, and due to the cause	ace, and due to the ca se(s) and manner as s	ause(s) and manner stated. tated.
	్ ్ ప		(De mo	D00 6		30	Date signed (Month,	∪ау, теаг)
	Cont		30. Name and address of person who completed cause of death (Item 23a) (Teric Park MD 8600 Old Georgetown 31. Date filed (Month, Day, Year) 22. Registrar's Signature	Road Bethes	sda, MD 2	0814		
	State Registra		31. Date filed (Month, Day, Year) 2. Registrar's Signature	backer				

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 13, Day 011 Alfred J. Bridy 9:50 AMMedical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Suburban Hospital Bethesda Montgomery If Under 1 Year If Under 24 Hrs. Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Hours 577-60-1928 1 ፟ M 2 ☐ F Days 1272471910 Pennsylvania 100 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County filed within 72 hours after death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Montgomery Chevy Chase 1^X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8100 Connecticut Avenue Apt. 1006 20815 United States 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I once. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Lawyer Law Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Lorenzo Bridi Alceste Zanneti 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Dillon / Daughter 19351 Frenchton Place Montgomery VIIlage, MD 20886 20b. Place of Disposition (Name of cemetery, crematory or other place)
Gate of Heaven Cemet. 3/19/2011 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Silver Spring, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons Inc. Signature of Funeral Service License 5130 Wisconsin Ave. NW Washington, DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ Heart Block disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Anemia To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Acute Renal Failure Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year n signed by the a 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy perform death? certificate 2 No Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🛣 No Other: 은 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 3/13/11 1)65312 MOMPHAN SIM MI) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sudarshan Siva MD 8600 Old Georgetown Rd. Bethesda, MD 20814 31. Date filed (Month, Day, Year) **MAR 21** 2011 2. Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

JOHN A. BRADSHAW, III March 20, 2011 9:38 P			For State Registrer 1. Decedent's Name (First,	Middle Last				ertificat			1		Reg. No		1 0 5 7	
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## ROCERT H. Bradispay. Tr. ## State of the least of complications that caused the death. Do not each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause of each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause on each line. ## Approximate shock, or heart failure. List only one cause of death list on the cause of list of the cause of death of list on the cause of list of list on the list o	181	rai	6 Minden Ave													
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Registrar DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
Amend 24a per med cert 6914 4/6/11 dk
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Margaret Ruth Burns : 12 AM Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Lecation of Death 4c. County of Death Comico TO5 a 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth Funeral 1 □ M 2 🎛 F Months Davs Hours 05/29/1924 217-12-3491 Maryland Director 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Examiner must be notified at Director 1X Yes 2 ☐ No Maryland Wicomico Pittsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a Funeral 21850 USA 35184 Diva Court 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Force Black, White, etc. 1 Yes 2 K No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify white Completed 3 X Widowed 4 □ Divorced any injury or other traumatic event, the Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Telephone Operator Phone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Evelyn McCollough James Kersey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Michael E. Burns/son 300 Somerset St., Apt. A303, Ocean City, MD 21842 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Crematory 3/15/2011 Salisbury, MD 1. Sy nature of Funeral Service Licensee 2HOTTOWAY FUNETAL Home Professional Association Javie 4 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Edvance Physician/ Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed lined in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?
1 ☐ Yes 2 🔀 No Month Day Year 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? è 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed' death? 2 🗌 No Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 X No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 X Natural 5 Pending work? Accident 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4

Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 03-13-2011 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GREGORIO M. BELLOSO, M.D. 5302 (HINABERRY DR., SALISBURY, MD 21801 Year) 32. Regetrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Mildred Bennett MARCH Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death TENIN SULA 54613hU1 UI comi do IONAL edical Social Security Numbe If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🛣 F Months Days Hours Min. 6-18-1929 Country)
Maryland **Director** 218-24-7397 Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits must be notified at Director 1 Tes 2 No Wicomico Salisbury 10e. Street and Number 0 10f. Zip Code 10g. Citizen of What Country? Funeral 23a 737 Richwil Drive 21804 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, th Medical Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. ò ð 1 Never Married 2 Married Maryland 21215-0036 Yes. Give 1 ☐ Yes 2 X No Specify: White Completed 3 X Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 11 other t Homemaker permit. Page 1 and 2 should be filed w Department of Health and Mental Hygi Important: If item 27 is marked othe any injury or other traumatic event, ? Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Willey Lloyd Nora 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tammy Farley - Daughter Shady Creek Way, Salisbury, MD 21804 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Springhill Memory Gds 3-21-2011 Hebron, Maryland 21. Signature Fyneral Service Licensee 22. Name and Address of Facility Bounds Funeral Home 705 E. Main Street, Salisbury, Maryland 21804 23a. Part 1. Enter the disease, or concretations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ SCHEMI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examine if any, leading to immediate Due to (or as a consequence of): bunal-transi that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical certificate be 23c. If yes, outcome of pregnancy
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uneral Director: After the filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Watural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. npleted (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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Division of Vital

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Funeral Director		5. Social Security N 168-24-44		6. Sex 1 X M 2 □ F	7. Age (Ir	n yrs. la <i>st bi</i> 81	rthday) Yrs.	If Unde Months	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Bir (Month, D) 02/18/	1930	P	Coun	ace (State or try) sylvan:	
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Vith Vith Com	Σ	29b. Signature and	title of certifie	er \				2		se number	27		29d. D	ate signed	(Month,	Day, Year)	
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TIVA		30. Name and add	DCVI	who completed cau	se of deat	th (Item 23a) (Type,	Print)	} .	Sal	isb	un	MO	7	18	04-	
Sta Registr		31. Date filed (Mor	nth, Day, Year)	G 2011	Registrar's	Signature	h	har								,	
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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month Year 52 M 13 2011 March Noah David Barkley 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Wicomico 28654 Ocean Gateway Salisbury If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 1**X** M 2□ F Davs Months Hours Dec. 6, 1959 218-72-5237 Marvland 51 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 □Yes 2¥ No Maryland Wicomico Salisbury 10g, Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 28654 Ocean Gateway 21801 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Black 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Porter Giant Foods, Inc. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Agnes Marie Savage Noah Morris Barkley 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zp Code) 28654 Ocean Gateway, Salisbury, MD 21801 Ryan Barkley/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 E Burial 2 ☐ Cremation 3 ☐ Removal from State Springhill Mem. Gdns 03/21/2011 Hebron, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility 1213 Jersey Road, Salis ury, MD 21801 JOLLEY MEMORIAL CHAPEL 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Gause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of)

Physician /Medical Examiner

Physician

Examiner

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

/Medical

Directo

Funeral

Completed by

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To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the Iuneral director, page 2 should be detached for use as the burla-transit completely filled in by the Iuneral director, page 2 should be detached for use as the burla-transit

Division or Vital Records, P.O. Box 68760,

Examiner Physician/Medical þ Completed Be Medical Certification: To

F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		etopic pregnancy ther (specify)	23d. Date of delivery Month Day Year
art II. Other significant condition	s contributing to death but not resulting in the unde	rlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown
			24a. Was an autopsy performed? 1 ☐ Yes 2 ♣ No 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No
5. Was case referred to medical examiner?		26. Place of Deat	h (Check only one)
1XYes 2□ No	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient	3 □ DOA Other: 4 □ Nursing Ho	ome 5 X Residence 6 □Other (Specify)
7. Manner of Death 1. Natural 5 ☐ Pending 2 ☐ Accident investiga	28a. Date of Injury (Month, Day Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe how injury occurred
3 ☐ Suicide 6 ☐ Could no determin		, factory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)
(Check only 22 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)			

2180

State Registrar

31. Date filed (Month

eted cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

100 Ecarnil

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MAR 20 2011 LEONARD H. BIRNEY 5:15Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death NATIONAL NAVAL MEDICAL CENTER MONTGOMERY BETHESDA Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. . Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Dec 31, 1 X M 2 - F Months Days Hours Min. Director 225-34-0481 80 PA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director notified 28a-f VA Culpeper Amissville 1 Tyes 2 No 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ms 23a or must be Funeral 1380 Nelson Lane USA 12. Was Decedent Ever in U.S. Armed Forces?

1 12 Yes 2 No. 1 Yes, Give 1953 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. ral", or iter Examiner Black, White, etc. þ 1 Never Married 2 Married ve 1953 filed within 72 hours after Maryland 21215-0036 1 Yes 2 No Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates. 1955 White th and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical." 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner/ Plumbing Contractor Plumbing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important. If item 27 is marked of any injury or other traumatic eve မ Conrad H. Birney Emma Charlier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Elizabeth Ann Birney Wife 1380 Nelson Lane Amissville, VA 20106 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Quantico National Cem 3/25/2011 Triangle VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Moser Funeral Home, Inc CC0508 233 Broadview Avenue, Warrenton, VA 20186 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) SEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): -transit requires that the death certificate be executed Cause (Disease or imjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-Physician/Medical Box 68760 by the attending petached for use as f IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 🗌 Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an has completed filled in by the funeral director, page 2 autopsv performed? death? To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I 2 w No Yes 25. Was case referred to medical å 26. Place of Death (Check only one) examiner? Hospital: 2 🙀 No မ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 XNatural 5 Pending work? 2 No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at it. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 [only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 0101241525 (VA) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

MC_USA

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31. Date filed (Month, Da

NATIONAL NAVAL MEDICAL BETHESDA MD 20889-5600

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at angles. Physician /Medical Examiner

Baltimore, Maryland 21215-0036

Physician

/Medical

Examiner

Funeral Director

To the Hospital or Attending Physician: The law requires that the death certificate be executed cate has been signed by the attending physician and page 2 should be detached for use as the burial-tran-

Division or Vital Records, P.O. Box 68760, within 24 hours after death.

To the Funeral Director: After this certificate has be completely filled in by the funeral director, page 2 s

Sta Registrar

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	25. Was case reference warminer? 1 Yes 2 27. Manner of Dec 1 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	erred to medical No ath 5 Pending investigation 6 Could not I determined 1 Certifying P 2 Medical Exa	Hospital: 1 Inpa 28a. Date of In (Month, In be decomposed 28e. Place of building, Physician: To the beaminer: On the basis	atient 2 ER/O	utpatient 3 Time of Injury arm, street,	B DOA Oth 28c. Inju Wol 1 D factory, office curred at the ti	26. Place of Dec er: 4 Nursing F y at k? Yes 2 No me, date and plac opinion, death occ	24a. Was an autopsy performe 1 Yes 2 ath Check onl one 28d. Describe how 28f. Location (Stre City or Town,	24b. Were a prior to death? No 3 P	Probably 4 Unknow autopsy findings available completion of cause of s 2 X No ecify) Bural Route Number, as stated. ue to the cause(s)			
Sunitha Bhogavilli MD. 9801 Georgia Avenue. #117. Silver Spring, Maryland 20902	25. Was case reference warminer? 1 Yes 2 27. Manner of Dec 1 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	erred to medical No ath 5 Pending investigation of Could not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not to determine the could not be a second not be a second not to determine the could not be a second not to determine the could not be a second not be a sec	Hospital: 1 Inpa 28a. Date of In (Month, In be 28e. Place of building, Physician: To the beaminer: On the basis and manner	atient 2 ER/O	utpatient 3 Time of Injury arm, street,	BDOA Oth 28c. Inju Wor M 1 D factory, office curred at the trigation, in my 29c. Licens	26. Place of Dea er: 4 1 Nursing F ry at k? Yes 2 No me, date and plac opinion, death occ	24a. Was an autopsy performe 1 Yes 2 ath Check onl one 28d. Describe how 28f. Location (Stre City or Town, 29d. at the time, dat 29d.	24b. Were a prior to death? No 3 F 24b. Were a prior to death? No 1 Ye Ce 6 Other (Sp. injury occurred) et and Number or F State) se(s) and manner are and place, and du	Probably 4 Unknown autopsy findings available completion of cause of s 2 X No ecify) Rural Route Number, as stated. ue to the cause(s) onth, Day, Year)			
	25. Was case refeexaminer? 1 Yes 2 27. Manner of Det 1 Accident 3 Suicide 4 Homicide 29a. Certifier (Check only one)	Erred to medical No	Hospital: 1 ☐ Inpa 28a. Date of In (Month, In 28e. Place of building, Physician: To the be aminer: On the basis and manner	atient 2 ER/Onjury 28b. Day Year) 28b. injury - At home, firetc. (Specify) st of my knowledges of examination a stated.	utpatient 3 Time of Injury arm, street, le, death occurrence of the occurrence of th	B DOA Oth 28c. Inju Woi 1 factory, office curred at the ti tigation, in my 29c. Licens D005	26. Place of Dea er: 4 1 Nursing F ry at k? Yes 2 No me, date and plac opinion, death occ	24a. Was an autopsy performe 1 Yes 2 ath Check onl one 28d. Describe how 28f. Location (Stre City or Town, 29d. at the time, dat 29d.	24b. Were a prior to death? No 3 F 24b. Were a prior to death? No 1 Ye Ce 6 Other (Sp. injury occurred) et and Number or F State) se(s) and manner are and place, and du	Probably 4 Unknown autopsy findings available completion of cause of s 2 X No ecify) Rural Route Number, as stated. ue to the cause(s) onth, Day, Year)			

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 14, Day 2011 Year Physician/ Patrick Stephen Costello 8:01 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Kline Hospice House Frederick 7. Age (In yrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. Aug. 30, Year 1948 1 🕱 M 2 🗆 F Hours Director 62 Yrs D.C. 216-50-6602 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 27 is marked other than "natural", or items 23a or 28a-f s traumatic event, the Medical Examiner must be notified MD Frederick 1 Yes 2 X No Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7126 Canterbury Court 21703 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give XX No Baltimore, Maryland 21215-0036 Specify: White 1 Yes 2 No Specify: 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) History Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic William Patrick Costello Evelyn Broderick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Matthew J. Costello/Son 334 14th Place, NE, Apt. 1, Washington, DC 20002 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Durial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, 21. Signature of Funeral Service Acensee 22. Name and Address of Facility ancis J. Collins Funeral Home Inc; MD 20901 Hates Michaed L 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Asystole disease or condition seconds Medical resulting in death) Due to (or as a consequence of): **Examiner** Hypoxia minutes Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): t-transit that the death certificate be executed Cause (Disease or linjury that initiated events hours Due to (or as a consequence of): resulting in death) Last burialphysician s the burial Physician/Medical Hepatic Encephalopathy days attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day Year 2 No 1 Yes 2 L 9 Unknown 9 Unknown by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, Melanoma Metastatic to Liver 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown has been sig je 2 should b 24b. Were autopsy findings available prior to completion of cause of death? Hepatic Failure 24a. Was an page ! performed? Yes 2 A N 1 Yes 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 🔼 No Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☒ Other (Specify) 1 🗌 Yes ျှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pr within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate; 1 Natural 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier

Registrar DHMH 17 Rev 7/2009

12

State

Yun Oh,

31. Date filed (Month, Da

MD

Box 68760

P.O.

Division of Vital

40B Thomas Johnson Drive, Frederick, MD 21702

MD

Registrar's Signatur

30. Name and address of persor who completed cause of death (Item 23a) (Type, Print)

29c. License number

D67442

29d. Date signed (Month, Day, Year)

March 15, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend \$5perfn, g-916, 6-27-11 do State of Maryland / Department of Health and Mental Hygien 1 - State AMEND#4a, 24a/24b; 25penMD, 3-18-2011; BMC MARIC ate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Month 03/07/ Physician/ Jenny Melanie Caceres 19:42 p_M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Silver Spring Montgomery y Cross Hospital 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 213-65-9898 **Funeral** Months Days Hours 1 □ M 2 👽 F El Salvador 29 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10d. Inside City Limits Examiner must be notified at 10c. City. Town or Location Director New Carrollton Mr. Prince George 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral with 23a 20784 El Salvador 7713 Riverdale Rd. items ? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after death 12. Was Decedent Ever in U.S. 11 Marital Status 14 Race - American Indian. Armed Force Black, White, etc. ŏ 1 X Never Married 2 ☐ Married Yes 2 No Completed by Maryland 21215-0036 1 X Yes 2 No Specify: El Salvador If Yes, Give Specify: Hispanic "natural", 3 Divorced 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. 9th Maintenance University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Maria Mercedes Caceres Herminio Reyes Orellana and 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Heatth ar Important: If item 27 is any injury or other trau 7713 Riverdale Rd. New Carrollton, Md. 20784 Carlos Colon/Boyfriend Raltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
General Cemetery 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/23 /1 El Salvador 21. Signature of Funeral Service Licensee John T. Rhines Funeral Home 3005 22. Name and Address of Facility 12th St. NE Washington D.C. 20017 23a. Part 1. Enter the disease, or complications that caused the death. To not enter the mode of dying, such as cardiac or respiratory arrest, shock, heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Physician/ Amniotic Fluid Embolisation disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Myocardial Infarction, DIC, Haemorragic Shock, Ecquentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): Acute renal Failure, Encephalopathy, ARDS, burial-transi and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Physician/Medical Cardiopulmonary Arrest, Coma, Ac. Bld. Loss, Anemia the Charlette-OK As IS (verbal) Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Pregnant at time of death 1 Yes 2 9 Unknown 2 🗌 No 9 Unknown be detached 03/06/2011 signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Pregnancy 1 ☐ Yes 2 📝 No 3 ☐ Probably 4 ☐ Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 X No 1X Yes 2 ☐ No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director. After this certifica completed filled in by the funeral director, p. 25. Was case referred to medica Be 26. Place of Death (Check only one) 1 XYes 2 □ No Other: 4 Nursing Home 5 Residence 6 Other (Specify, မ 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury X Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) Ashwini

State Registrar

DHMH 17 Rev 7/2009

7

82. Registrar's Signature

1500 Forest Glen Rd. Silver Spring, Md. 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Dr. Ashwini P. Pandit

31. Date filed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2 Date of Death 17^{Pay} Physician/ March 20ÎÎ 12:02 A M Dona 1d Eugene Clipp Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 16813 Longfellow Court Hagerstown Washington 9. Birthplace (State or Foreign Country) Maryland Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 M 2 □ F Days Min 3/9/1954 Director 220-54-4900 57 Usual Residence of Decedent 28a-f show 10a State 10b. County ral", or items 23a or 28a-f shor Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Washington Hagerstown 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 16813 Longfellow Ct. 21742 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.

is marked other than "natural", 1 Yes 2 No Specify. 3 Widowed 4 Divorced White Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Owner Retail Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ David Edwin Clipp Catherine Louise Foltz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret L. Clipp / Spouse 16813 Longfellow Ct., Hagerstown, MD 21742 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other placel 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Rest Haven Cemetery 3/21/2011 Hagerstown, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rest Haven Funeral Chapel U 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one care that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine Due to (or se a consequence of): if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events and -transit that the death certificate be executed Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Day Year Pregnant at time of death 2 No ed by the a 9 Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an has e 2 autopsy performed pade Hospital or Attending Physician: The this certificate 1 ☐ Yes 2 ☐ No Yes 2 No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 X Residence 6 Other (Specify) Hospital 1 Tes 2 No ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of nours after death. neral Director: After the filled in by the funera Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide injury 5 Pending work 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier 1 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 24 Certifying Nurse Practioner: To the best of my knowledge, death conserved at the tare, date and place, and due to the cause(s) and mainly a stated 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TH-2 L 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) 1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 7,2011 WILSON CLEVER TROVER lacc /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner washington Marylary Fanney Keedy
5. Social Security Number 6. Set Nursing Home Boonsporo, If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 7. Age (In yrs. last birthday) Funeral 1 M 2□ F 203-10-3366 Pennsylvania Director 11/14/1918 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County ?7 is marked other than "natural", or items 23a or 28a-f show traumatic event, it a five item is a milier must be notified at 1 Yes 2 □ No Director MD Washington Boonsboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 8507 Mapleville Rd. 21713 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 Meyes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: ģ 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 11 <u>Transportation</u> <u>Fork Lift Operator</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 should be f and Mental I permit. Pages 1 and 2 should be Department of Health and Ments Important: If item 27 is marked any Injury or other traumatic e Harry 0. Clever Dorothy Lowan 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Diane T. Brining/ Niece in law 18721 Dover Drive, Hagerstown, MD 21742 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) Rest Haven Cemetery 3/19/2011 | Hagerstown, Maryland 22. Name and Address of Facility Rest Haven Funeral Chapel 21. Signature of Funeral Service Licensee 5 Mark 1601 Pennsylvania Ave., Hagerstown, MD 21742 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Chronic obstructive pulmonary disease years /Medical Due to (or as a consequence of): Examiner years Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 5 ☐ Other (specify) signed by the a d be detached f 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown funeral director, page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has After this certificate 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐Yes 2XINo 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred Division ospital or Attending hours after death. To the Hospina. ... within 24 hours after death.
To the Funeral Director: After a fine and the funeral Director of the funeral pilled in by the fur 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier

02H0+1

31. Date filed (Month, Day, Year) State MAR 18 Registrar

Khalid Waseem MD

1126 apoul Ct. egistrar's Signature 32.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Hagerstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ March 14, 11:10 AM Winifred Geneva Colding Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Prince George's Hospital Center Prince George's Cheverly If Under 1 Year If Under 24 Hrs Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 🗆 M 2 🔀 Months Days Hours Min. (Month, Day, Year) Country) **Director** 578-48-0584 Nov. DC Usual Residence of Decedent show 10a. State 10b County 10d. Inside City Limits filed within 72 hours after death with the Maryland "natural", or items 23a or 28a-f sho odical Examiner must be notified at 10c. City. Town or Location Director 1 X Yes 2 No Maryland Charles County Waldorf 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 3041 October Place 20602 United States #A 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: African American 1 ☐ Yes 2 🖾 No Specify: Completed 3 Widowed 4 X Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working permit. Page 1 and 2 should be flied within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ", any injury or other traumatic event; the Med once. other than " life. DO NOT use retired) General Elementary/Seconday (0-12) College (1-4 or 5+) 12th Procurement Specialist Service Administration Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alfred Colding Bernice Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Reginald Colding - Brother 10100 Cascade Lane Largo, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State March 19. Burial 2 ☐ Cremation 3 ☐ Removal from State Maryland National □ Donation 5 □ Other (Specify) Laurel, Maryland 2011 22 Name and Address of Facility Stewart Funeral Home, Inc. ature of Funeral S vice Lios see Sil 4001 Benning Road NE Washington, DC 20019 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Metastatic Gastric Cancer months) Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events and -trar resulting in death) Last Due to (or as a consequence of): burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FFMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🛣 No Month Day Year Pregnant at time of death page 2 should be detached g Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 2 🔀 No Yes 25. Was case referred to medical the funeral director, Be 26. Place of Death (Check only one) Hospital: 2 🔀 No မ 1 Tes 1 Inpatient 2 A ER/Outpatient 3 I DOA 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural iniury 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide completed filled in by determined 24 hours Medical 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b, Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) D46246 March 15, 2011 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

State Registrar M Ashraf Meelu M.D.

31. Date filed (Month, Day, Year)

MAR 2 2 2011

32. Registrar's Signatur

3200 Crain Hwy Suite 302 Waldorf, Maryland

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ Agnes Crouch Irene rarch Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Meritus Medical Center Hagerstown 5. Social Security Number Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, Year) **Funeral** 1 🗆 M 2 🗶 F Months Hours Min. Director 579-32-3687 85 02/15/1926 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director ٧A Fauguier Bealeton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 7754 Botha Road 22712 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black White etc. 1 Never Married 2 Married <u>ک</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 X Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Personnel Specialist should be filed with and Mental Hygien is marked other th Dept. of Army Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Acie Ross Thompson Mildred Louise Davis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Rebecca E. Crouch -Daughter 1404 Baker Place West #14 Fredrick, MD 21702 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) cemetery, crematory or other place, Chestnut Grove 03/31/2011 Herndon, VA 21. Signature of Funeral Service Licensee 22 Name and Address of Facility 721 Elden St. Herndon, VA 20170 Adams-Green Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ CORDIDE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Tive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine that the death certificate be executed y physician and strans Due to (or as a consecutor ce of) resulting in death) Last Physician/Medical attending IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☑ No for Pregnant at time of death 5 Other (specify) 9 Unknown Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an OMENTIA has autopsy performed? Yes 2 No page certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner?

1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 FR/Outpatient 3 ☐ DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of o the Hospital or Attending Pl vithin 24 hours after death. o the Funeral Director: After the ompleted filled in by the funeral 28c. Injury at 28d. Describe how injury occurred Certificate: work? injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Registrar

Michael

White

11116

32. Registrar's signature

3. Time of Death

9. Birthplace (State or Foreign

10d. Inside City Limits

Interval Between Onset and Death

Month

1 ☐ Yes 2 ☐ No

1 Yes 2 X No

Maryland

White

2011

0844 AM

Box 68760 P.0. Records, Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Gregory Marion Ciesielski March 21. 20Y1 4:55 A. Medical Facility Name (if not institution, give street and number) 3915 Dogwood Road 4b. City, Town, or Location of Death
Port Republic 4c. County of Death **Examiner** If Under 1 Year Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖫 M 2 🗆 F Months Davs Hours Min March, 25, 1936 Pennsylvania 220-30-5745 74 Director 28a-f show Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10d. Inside City Limits 10a State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director Maryland Port Republic Calvert. 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States Funeral 3915 Dogwood Road 20676 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 X Yes 2 No If Yes, Give 53-57 Year or Dates. Baltimore, Maryland 21215-0036 Speciwhite 1 Yes 2 No Specify: 3 🔀 Widowed 4 🗆 Divorced Completed Medical 15. Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) the Public School teacher traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Genevieve Golaszewski Henry Francis Ciesielski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. Marcianna Kreamer-daughter 1185 White Sands Drive Lusby, MD 20657 20a. Method of Disposition 20b. Place of Disposition (Name of March 24 2011 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State St. John Vianney Cemetery Prince Frederick Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Rausch Funeral Home 21. Signature of Funeral Service Licenses 4405 Broomes Is. Rd. Port Republic, MD 20676 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Retween Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner 50 Sequentiary list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last and Due to (or as a consequence of): signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 as IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year 5 Other (specify) Pregnant at time of death detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 has Director; After this certificate 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify, ER/Outpatient 3 DOA 1 Inpatient 2 I 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the I Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) ☐ Homicide 24 hours 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 20a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one 29b. Signature and title of certifier 05224

DHMH 17 Rev 7/2009

Registrar

Hospital Road Prince Frederick, MD 20678

32. Registra

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

J. Barth, M.D.

31. Date filed (Month, Day, Ye

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 2011 Month **Physician** March 16, 1:30 p M James W. Cash /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Frederick Frederick Citizens Care & Rehabilitation Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 6 Sex **Funeral** 1**X** M 2□ F 91 432-48-3843 Director Nov 11, 1919 Arkansas Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County item 27 ie markad other then "naturel", or itams 23a or 28e-f show other traumetic event. If ∞ McJi⊆al Exarid must ke notified at 1X Yes 2 □ No Frederick Maryland Frederick Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21702 USA 2500 Catoctin Ct #24 by Funerai Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: If Yes, Give Year or Dates: white 3 Widowed 4 ☐ Divorced WWII Compieted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry . Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) U.S. Navy Air Mechanic 12 and Mental Hygi 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pearl Ouinn James M. Cash 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 220 N. 5th Street, McSherrystown, PA 17344 t of Health Robert E. Clements, nephew Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ■ Burial 2 □ Cremation 3 □ Removal from State injury or Department of Importent; If any injury or once. 3/19/2011 Suitland, MD Cedar Hill Cemetery `4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licensee 91 Willis Street, Westminster, MD 21157 23a. Part | Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. Approximate Interval Between Onset and Death Heretens Di to (or as a con-Immediate Cause (Final Physician disease or condition resulting in death) /Medical to (or as a consequence of): **Examiner** Sequentially list conditions, cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed burial-transit Due to (or as a consequence of): Box 68760, physician Physician/Medical the as attending IF FEMALE: esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy jo in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 Other (specify) 4☐Pregnant at time of death P.0. the detached 9 Unknown signed t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, þ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 No 24a. Was an page 2 autopsy 1 ☐ Yes tilled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 2 No Nursing Home 5 Residence 6 Other (Specify) 2 1 🗌 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred : After t Certification: 28b. Time of or Attending 1 Natural 2 Accident 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. Diractor: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗀 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) within 2 To the To the 29d. Date signed (Month, Day, Year) 29b. Signature ar 29c. License number 20745+1VA e of death (Item 23a) (Type, Print) KAUFFMAN 21701 FREDERICK 300 REDERT w NINTH STREET MD

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Year)

MAR 18 2011

parke

32. Registrar's Signature

4b. City, Town, or Location of Death

If Under 1 Year | If Under 24 Hrs.

Crisfield

March

Date of Birth (Month, Day, Year) 08/31/1927

19,

2011

Somerset

4c. County of Death

CHARNOCK

7. Age (In yrs. last birthday)

83

0593

5:00 A M

21/2011

Birthplace (State or Foreign Country)

Virginia

		/Medi Exami	ical
4-		uneral irector	16
	vith the Maryland	or 28a-f show be notified at	Director

ANNIE

5. Social Security Number

226-36-5268

Usual Residence of Decedent

4a. Facility Name (If not institution, give street and number)

Alice Byrd Tawes Nursing Home

6. Sex

1 🗆 M

VIRGINIA

permit. Pages 1 and 2 should be filed within 72 hours after death wi Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or items 23a any lijury or other traumatic event, the Medical Examiner must by once. **Physician**

Baltimore, Maryland 21215-0036

/Medical Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

	10a. State 10b. County		10c. City, Town	or Location					10d. Inside City Limits		
ctor	Virginia Accoma	ıck		Tangie	r				1XYes 2 No		
ire.	10e. Street and Number			10f. Zip C	ode		10g. Citi	zen of What Co	untry?		
a D	16078 Main Street				23440			U.S.A.			
uner	11. Marital Status 1 ☑ Never Married 2 ☐ Married	12. Was Decedent Armed Forces?		13. Was Decede if Yes, specif	nt of Hispanic Origin? (y Cuban, Mexican, Pue	Specify Yes or No erto Rican, etc.)	-	14. Race - Ame Black, White			
l by F	3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 反 If Yes, Give Year or Dates:	NO	1 ☐ Yes 2	No Specify:			Specify: Wh	nite		
To Be Completed by Funeral Director	15. Decedent's Edi (Specify only highest grad	de completed)	171	Decedent's Usual (Give kind of work life. DO NOT use	done during most of w	orking	16b. Ki	nd of Business/	Industry		
E	Elementary/Secondary (0-12) 12	College (1-4or 5	· _	ner			Sar	ndwich S	Shop		
O	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle,	Maiden	Surname)			
To B	John Wesley Charn	ock			Dora	Ellen Pa	rks				
	19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip										
	Sandra King (Niece) P. O. Box 47 - Tangier, VA 23440 20a. Method of Disposition (Name of Date 20c. Location - City or										
	20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		cemeter	ck Family	er place)	/22/2011			irginia		
	21. Signature of the local Strate Liouns	see		Bradshav	Address of Facility W & Sons Fu Main St. —	neral Ho	me v	ID 2181	7		
	23a. Part1. Enter the disease, or comp shock, or heart failure. List only commediate Cause (Final disease or condition resulting in death)	a	d the death. Do none. / a consequence o	ot enter the mode	of dying, such as cardi			2101	Approximate Interval Between Onset and Death		
Completed by Physician/Medical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease of Injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Due to (or as a consequence of):										
ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Fetal death	3 ☐ Ectopic pred				23d. Date of del Month	livery Day Year		
古	Part II. Other significant conditions co	ontributing to death b	ut not resulting in	the underlying cau	ıse given in Part I.	23e. Did t	obacco u	ise contribute to	the cause of death?		
D D						10	Yes 2	XNo 3 □ Pr	robably 4 Unknown		
Complete						24a. Was autoj perfo 1∐ Yes		prior to death?	utopsy findings available completion of cause of		
Be	25. Was case referred to medical examiner?				26. Place of D	eath <i>(Check only c</i>	ne)				
0	1 Yes 2 XNo	Hospital: 1 ☐ Inpatie	ent 2 ER/Out	patient 3□ DOA	Other: 4 Nursing	Home 5 ☐ Resi	dence	6 □Other (Spe	cify)		
ation: T	27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		y 28b. Time of 28c. Injury at 28d. Describe					pe how injury occurred		
ertifica	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	20e. Flace of III]	Place of injury - At home, farm, street, factory, office 28f. Location (Street and City or Town, State)					d Number or Ri	ural Route Number,		
Medical Certification:			f examination and		t the time, date and pla n my opinion, death oc						
<u>Je</u>	001 81			200	Licence number		20d Do	to signed /Most	th Day Vand		

State Registrar

par

30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year)

32. Registrar's Signature

D48098

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 02 Physician/ Clarice W. Cole 06:50 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Town, or Location of Death pice at the Nicomico ISLOUR 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 🗆 M 2 🔀 F Months Hours (Month, Day, Year) 2 23 1960 216-70-6314 **Director** Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland injury or other traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a or by Funeral USA 29028 Raven Court 21801 permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 X Married and 21215-0036 If Yes, Give 1 ☐ Yes 2 🙀 No Specify: Specify: Black Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Delmarva Home Care Elementary/Seconday (0-12) College (1-4 or 5+) Solutions CNA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Goldie Johnson William A. Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 906 East Rd., Salisbury, Maryland 21801 Michael Cole son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 03|16|2011|Salisbury, Maryland 4 Donation 5 Other (Specify) Parsons Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility elly Stewart Euneral Home by Holloway and 821 West Rd, Salisbury, MD 21801 Well R Downey P.A., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) METASTATIC Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner day leading to in medic cause. Enter Underlying Cause (Disease or iinjury Dualte for as a consumer of the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Other (specify) ate has been signed by the a page 2 should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 🔲 Yes Yes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, p. Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? Matural Natural 5 Pending Investigation 6 Could not be ☐ Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie (Check only on Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. d title of certifie 29d. Date signed (Month, Day, Year) 2005 3410 and address of person who completed cause of death (Item 23a) (Type, Print 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Year Month Angela 03 Case 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Social Security Number ficom ico TENINS4LA 9. Birthplace (State or Foreign Country) Pennsylvania 8. Date of Birth
(Month, Day, Year)
8-1-1927 Funeral 6. Sex If Under 1 Year If Under 24 Mrs. 1 M 2 🗓 F Days Director 219-10-9724 83 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 X No MD Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1005 E. Schumaker Manor Drive USA 21804 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 14. Race - American Indian, 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n College (1-4 or 5+) Elementary/Seconday (0-12) Own Business Private Detective Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Vincent Russoniello Anne 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 2 s Health EJ Foxx/Personal Representative 1003 Schumaker Manor Drive, Salisbury, MD 21804 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 s Department of H Important: If ite any injury or ot cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crematory of Delmarva 3-18-2011 Delmar, Delaware Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ minth disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner oronemy arters LEWIS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events physician and the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical IÉ FEMALE: 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death in the past 12 months? Dav 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mctastatic breast Cancer Records, 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 1 Yes 2 No Yes 2 1 NO To the Hospital or Attending Physician: Within 24 hours after death.

To the Funeral Director, After this certification properties of the funeral director, to the funeral director, the funeral director is the function of the func 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 46 Other: 1 Yes 2 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier March 17, 2011 D39204 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) E. Carroll St, Salisbury, MD PRMC Bennett 100 State Registrar

DHMH 17 Rev 7/2009

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Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March Day 2011 Mildred Margaret Donithan 14 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death Westminster 4c. County of Death Carroll County Carroll Lutheran Village 5. Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea Feb. 5, **Funeral** 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Days Hours Maryland 219-22-0644 **Director** Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director must be notified Maryland Carroll County Hampstead 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 109. Citizen of What Country? Funeral 23a 4353 Sycamore Drive 21074 United States items Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iter edical Examiner 14. Race - American Indian, Black, White, etc þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify white Completed 3 X Widowed 4 Divorced th and Mental Hygiene.
27 is marked other than "nature traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Leo Andrew Marr Ruth Wilson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 445 Hand Court Hampstead, Maryland 21074 of Health Ken Donithan / son Baltimore, other t; If item 20a. Method of Disposition March 17, 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗔 Removal from State Department of Important; If any injury or once. Hampstead Cemetery Hampstead, Maryland 4 Donation 5 Other (Specify) 2011 21. Signature of Funeral Service Licens 22. Name and Address of Facility Eline Funeral Home 934 South Main Street M01072 Hampstead, Maryland 21074 Turves 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Alzheir Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any hading limited in the second Examine Due to for esta nonsectionne off cause. Enter Underlying been signed by the attending physician and should be detached for use as the bunal-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day 9 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ★No 24a. Was an autopsy performed? Yes 2 XN the Hospital or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4X Nursing Home 5 - Residence 6 - Other (Specify) 1 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) answaya, Mr D 51705 03-15-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

M. PANSURIYA 2111 Hanova

Registrar

State

ANSURIVA

31. Date filed (Month, Day, Year)

32. Registrar's Signature

Pile

Hampstead MI) 2674

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 10ay 20 IT March 11:28 P M Jospehine M. DeLeo Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Washington Williamsport 16906 Reading Drive Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday **Funeral** 1 □ M 2 🛚 F Days April Day 1 1 , 1924 **Director** Pennsylvania 86 210-12-4169 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 XYes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21701 United States 6351 Spring Ridge Parkway 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Completed 3 X Widowed 4 ☐ Divorced White Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Helen Smith Harry Cole 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16906 Reading Dr., Williamsport, MD 21795 Cristalle Grove / Granddaughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Toremation 3 Removal from State 3/11/2011 Stauffer Crematory Frederick, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service License Stauffer Funeral Home out the 1621 Opossumtown Pike, Frederick, MD 21702 234 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death OVARIAN Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Day Pregnant at time of death 5 Other (specify) cate has been signed by the a page 2 should be detached 9 I Inknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ours after death. eral Director: After this certificate has b filled in by the funeral director, page 2 sl performed? Yes 2 No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 X Other (Specify) examiner? Hospital 2 No Other: ၉ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral C Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of certifier 021936 melom 1. Name and address of person who completed cause of death (Item 23a) (Type, Print)

A. DONE WON, MD 65C THOMAS VOLLNOON DL. FREDERICE 10 21702

DHMH 17 Rev 7/2009

State Registrar

31. Date filed (Month, Day, Y

Year)

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item 24a per Waryland Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 2011 11:19A M ADA VELIA DIZEBBA Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 114 HAWTHORNE GREEN CIRCLE CHARLES LAPLATA5. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs, last birthday) **Funeral** 1 🗆 M 2 🕱 F Months Days Hours Min AUG**, 89, 1929 PENNSYLVANIA 577-34-3819 Director 81 Usual Residence of Decedent ms 23a or 28a-f shov must be notified at 10d. Inside City Limits 10a. State 10b. County within 72 hours after death with the Maryland 10c. City. Town or Location Director LA PLATA MD CHARLES XXYes 2 \(\text{No} \) 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 114 HAWTHORNE GREEN CIRCLE 20646 U. S. A. permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hyglene.
Dipportant: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Force Black, White, etc. 1 Never Married 2 Married Yes 2XXNo Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) HOMEMAKER AT HOME Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ GIOVANNI MEROLLI VERA PANTALEONI t. Page 1 and 2 should be rument of Health and Mer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DENISE QUINN/DAUGHTER 30115 DUDLEY RD., MECHANICSVILLE, MD 20659 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State MARCH tx Burial 2 ☐ Cremation 3 ☐ Removal from State netery, crematory or other place) VETS • CEMETERY MD 4 Donation 5 Other (Specify) 28,2011 CHELTENHAM, MD 22. Name and Address of Facility RAYMOND FUNL. SERVICE, P Signature of Funeral Service M00641 5635 WASHINGTON AVE., LA PLATA, MD'20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Ph sician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi and that initiated events resulting in death) Last Due to (or as a consequence of): signed by the attending physician d be detached for lise as the board Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Dav Year 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed neec 24b. Were autopsy findings avallable prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an After this certificate has autopsy performed Yes 2 25. Was case referred to medical examiner? funeral director, 26. Place of Death (Check only one) Be 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28b. Time of 28d. Describe how injury occurred injury 1 Natural 5 Pending Accident death. Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, 24 hours a Medical 29a. Certifier 🌠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the within 2 only one 29b. Signature and title of certifier

State

Registrar

LINE CENTAL WAURUF, Add 20602

no completed cause of death (Item 23a) (Type, Print)

2. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 15,2011 Physician/ 3:40 A Rochelle Dowtin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Clinton, Maryland Future Care Pineview 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) ine 9, 1970 Days Hours Min 1 M 2 TE F 577-92-5830 Washington DC Director 40 June Usual Residence of Decedent 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location death with the Maryland Examiner must be notified at Director M Yes 2 □ No laryland Prince George's Oxon Hill 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5202 Leverette Street 20745 United States "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. 11. Marital Status Black, White, etc. þ 1 X Never Married 2 Married 1 ☐ Yes 2 🛣 No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 Yes 2X No Specify. Specify: Black 3 Divorced Completed Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) than permit, Page 1 and 2 should be filed within i Department of Health and Mental Hygiene Important; If item 27 is marked other than any injury or other traumatic event. the M. Elementary/Seconday (0-12) College (1-4 or 5+) Disabled None Tenth None Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Sarah A McKevie Wade Lee Dowtin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sarah Dowtin/Mother 5202 Leverette St.,Oxon Hill, MD 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ₺ Burial 2 □ Cremation 3 □ Removal from State Harmony Memorial 3/25/2011 Landover Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of FacilityRobert G Mason Funeral Home Inc 21. Signature of Foreral Service Licensee Donald R 1661 Good Hope Rd SE, Washington DC 20020 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physiciani disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or imiury attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Month Dav Year 5 Other (specify) Pregnant at time of death n signed by the at Id be detached fo a | Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 \square Yes Completed phods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy perform 1 ☐ Yes 2X No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: ျ 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 5 Pendina 2 No 2 Accident
3 Suicide
4 Homicide Investigation

or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page

within 24 hours a

To the Funeral D To the Hospital

State

Medical

29a. Certifier

only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NAQV 83 Smith

32. Registrar's Signature

6 Could not be

2 3

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 0 4 2011

determined

Registrar DHMH 17 Rev 7/2009 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

Location (Street and Number or Rural Route Number, City or Town, State)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ COL Medical 4a. Facility Name (if not institution, give street and number 4b. City, Jown, or Location of Death 4c. County of Death **Examiner** Elchar Washington 10 Calv If Under 1 Year Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) 1 🗆 M 2 🔀 F Days Hours July 29,1932 Washington, D.C. 78 579-44-0439 **Director** Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits Ħ 10c, City, Town or Location Director Examiner must be notified 1 Yes 2 No Maryland Fairplay Washington 9 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21733 8420 Reichard Rd. death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ò 1 Never Married 2X Married þ 1 ☐ Yes If Yes, Give Maryland 21215-0036 72 hours after 1 ☐ Yes 2X No Specify Specify. "natural", Completed 3 Divorced White Year or Dates other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) other than Elementary/Seconday (0-12) College (1-4 or 5+) 12 Home Housewife 18. Mother's Name (First, Middle, Malden Surname) 17. Father's Name (First, Middle, Last) and Mental မ Bowling Joseph Charles Bergling Ruth Frances 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) <u>s</u> permit. Page 1 and 2 st Department of Health ar Important: If item 27 is any injury or other trau 8420 Reichard Rd. Fairplay, Maryland Hubert Eaton-Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 B oval, from State Hagerstown Crematory March 18,2011 Hagerstown, Maryland 4 Donation 5 Other (Sp Osborne ABunerally Home, P.A. e of F 425 S. Conococheague St. Williamsport, MD 21795 disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 1. Enter the shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examir Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last -trar Due to (or as a consequence of): burial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year ☐ Pregnant at time of death☐ Unknown 9 Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown cate has been signage 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2 No 1 🗌 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one, Hospital 2 XNO Other: 1 Tyes ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Tes 2 🗆 No 2 Accident
3 Suicide Investigation Director; / 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined the Funeral Di Medical 29a. Certifier 1 🗡 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examination on the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Fractioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29d. Date signed (Month, Day, Year) 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21742 3H-4

DHMH 17 Rev 7/2009

State

Registrar

Chuckia N. Bro 31. Date filed (Month, Day, Year,

MAR 17

32.

Brown-Tisdale, M.D. 11110 Medical Campus Rd. Suite 143 Hagerstown, MD

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene_ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 3:04 A M BENJAMIN SEWARD EVANS, IV 03 Medical 12 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Salisburg oastal Hospice A+Lake TICOMICO Social Security Number If Under 1 Year If Unde **Funeral** . Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1 X M 2 🗆 F Months Davs Hours (Month, Day, Year) Director 212-72-2393 50 Florida Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a. State 10c, City, Town or Location 10d. Inside City Limits Director 1 🔀 Yes 2 🗌 No Maryland Somerset Crisfield 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? Funeral 21817 74 Somers Cove Apartments USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. Completed by 1 Never Married 2X Married altimore, Maryland 21215-0036 If Yes Give 1 ☐ Yes 2 😾 No Specify: White Specify: 3 Divorced 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Housing Elementary/Seconday (0-12) College (1-4 or 5+) 12 Grant Writer Authority Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Benjamin Seward Evans, III Julia Roberta Landon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah Evans (Wife) Somers Cove Apts. Crisfield, MD 21817 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Sunnyridge Mem. Park 3/16/2011 Crisfield, MD 21. Signate of Facility BRADSHAW & Mary Beth Bradshaw Pruitt 306 W. Main St. - Crist 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 22. Name and Address of FacilityBRADSHAW & SONS FUNERAL HOME Crisfield, MD Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ pronchogenie disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence or) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year signed by the at Id be detached fo g Unknown Part II. Other significant conditions contributing to death but not resylting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 No Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate | completed filled in by the funeral director, pag 1 ☐ Yes 2 🗷 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 🔀 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation

Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 03-12-2011 lles 29505 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5302 CHINABERRY DR., SALISBURY, MD 21801 GREGORIO M, BELLOSO: 31. Date filed (Month, Day, Year) 32. Regi trar's Signature

DHMH 17 Rev 7/2009

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death edent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner inthici NNE ARUNDE If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday **Funeral** 1 M 2 □ F nth, Day Months Hours Yrs Director 28a-f shov 10d. Inside City Limits 10a, State 10b. Count 10c. City, Town or Location Examiner must be notified at Director 1 🗌 Yes 2 🗹 No 10g. Citizen of What Country? 10e. Street and Numb 10f. Zip Code 23a Funeral items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces? Black, White, etc. ō ☐ Yes 2 🗹 No ş 1 Never Married 2 Married 1 Yes 2 c If Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: Whi "natural", 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) RATOR other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last permit. Page 1 and 2 should be filed.
Department of Health and Mental Hy
Important: If item 27 is marked otf
any injury or other traumatic even ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 985 ReanLeigh LA. 21401 20a. Method of Disposition 20b. Place of Disposition (Name Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3-28-11 ODENTON, MD. Signatur of Fure 22. Name and Address of Facility DURNERTY FUNERAL HOME 2601 MOUNTAIN RD. PAKADENA, MD. 21122 100942 Approximate Interval Between Onset and Death Part 1. Enter the disease or complications that caused shock, or heart failure. List only one cause on each line. caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Immediate Cause (Final Physician/ 1 pma (CI STO STA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, it cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to or as a consequence of Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the futeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IE EEMALE 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Year Month Dav Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed Yes 2 1 Yes 2 No 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospics House 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 □ Yes 27, Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1. Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature 29c. License number and address of person the completed cause of death (Item 23a) (Type, Print) alen Bringe Q, Da Date filed (Month)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Year Month Physician Pau 1 21.50 13 March 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** 2/5/1950 New Jersey 143-44-0281 61 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10h County ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 1 ☐ Yes 2 XNo Directo Fairfax Fairfax VA 10g. Citizen of What Country? 10f. Zip-Code 10e. Street and Number 22032 USA 5130 Lavery Court Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes If Yes, Give within 72 hours after 1 Never Married 2 Married SpecifyCaucasian 1 ☐ Yes 2 X No þ 3 Widowed 4 Divorced Year or Dates Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) International College (1-4 or 5+) Elementary/Secondary (0-12) is marked other than Transportation Officer 4 Banking 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be filk Department of Health and Mental Hy Important: If item 27 is marked oth any Injury or other traumatic event Be Helen Dzurinko Michael Fesko ည 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 5130 Lavery Court Fairfax, Virginia 22032 Debora Hagan Fesko-spouse 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of Fall fax Memorial 3/19/2011 Fairfax, VA 4 ☐ Donation 5 ☐ Other (Specify) Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Fairfax Memorial Funeral Home 9902 Braddock Road Fairfax, V CC0423 Xam Bee 22032 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** SEPSIS disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): certificate be executed and Due to (or as a consequence of) attending physiciar Physician/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death 3 Ectopic pregnancy Month in the past 12 months? Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2. No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 2 No 2 No 1 Tes 1 Yes 26. Place of Death (Check only one) the funeral director, 25. Was case referred to medical Be Hospital: 1 Inpatient Other: 4 Nursing Home 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 5 ☐ Residence 6 ☐ Other (Specify) ၉ 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 ☑ Natural Certification: I or Attending I after death. within 24 hours after death.

To the Funeral Director: After Injury 5 Pending investigation 1 🗌 Yes 2 🗌 No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 ☐ Could not be 3 Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) determined completely filled in by 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier March 13 2011 15 RES-000 Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

BNTHONY

31. Date filed (Month, Day, Year)

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Baltimore, Maryland 21215-0036

Box 68760

P.O.

of Vital Records,

Division

3. Registrar's Signature

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month MARCH 2011 FOX 11:45 WILLIAM RONALD AM Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 25, 1948 If Under 1 Year If Under 24 Hrs. 6. Sex 1 ★ M 2 □ F 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Funeral Days Hours Maryland Director 219-46-1125 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Middletown Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2407 Tabor Drive 21769 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces' Black, White, etc. l Hygiene. other than "natural", or i 1 Never Married 2 X Married Completed by X Yes 1 ☐ Yes 2 🔀 No Specify: If Yes, Give White 3 Widowed 4 Divorced Year or Dates traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Distribution Clerk Postal Service is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William Edward Fox Edna Irene Walters 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sharon A. Fox / Wife</u> <u> 2407 Tabor Drive, Middletown, </u> MD 21769 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of H Important: If ite 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 03/22/2011 Frederick, MD 22. Name and Address of Facility Donald B. Thompson Funeral Home 21. Signature of Funeral Service Licensee 31 E. Main St., Middletown, MD 21769 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 10 x1 Physician/ 6Rain disease or condition Medical resulting in death) Examiner 10 e Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death Year Dav 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 performed? Yes 2 No 2 🗌 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 I 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check To the within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) March (IGM Name and address of person who completed cause of death (Item 23a) (Type, Print)

15+1

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Registrar

State

31. Date filed (Month, Day, Year) 32. Pysistrar's Signa

2. Prigistrar's Signature

DHMH 17 Rev 7/2009

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400 W. 7th St., Frederick, MD

21701

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ FLEMING YASMIN R 2:43 March 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital
Social Security Number | 6. Sex | 7. Age (In year) Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral March 13, 1 □ M 2 □XF Months 1955 Maryland - NY 56 **Director** 213-64-3294 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Frederick Thurmont 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12030 Old Frederick Rd. 21788 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify. If Yes Give Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) 12 College (1-4 or 5+) administrative specialist County Govt. Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Ith and Mental H 27 is marked of traumatic ever t. Page 1 and 2 should be fill thent of Health and Mental rant. If item 27 is marked Emma Fernandez Ferreira George M. Ramapuram 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12030 Old Frederick Rd. Thurmont, MD 21788 Thomas W. Fleming/husband permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State □ purial 2X Cremation 3 ☐ R
 □ Donation 5 ☐ Other (Specify)

21 gnatur of Full all Service Linence. 1 ☐ Burial 2X Cremation 3 ☐ Removal from State County Cremation 3/15/11 Sykesville, MD 22. Name and Address of Facility Hartzler Funeral Home 404 S. Main St. Woodsboro, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ end stage renal disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Diahetes mellitus Sequentially list conditions, Examine Dus to (or as a none-quarient of) If any, leading to immediate cause. Enter Underlying Hyperkasien for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Yes 2 No be detached 9 Unknown Records, P.O. Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Cerunary ackery disease 1 ☐ Yes 2 🗷 No 3 ☐ Probably 4 ☐ Unknown Completed within 24 hours after death.

To the Funeral Director. After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? recent methicillin resistant Staph aureus infection 24a. Was an performed 1 ☐ Yes 2 ☐ No of toes Status post amoutations 2 X No 25. Was case referred to medical of Vital 26. Place of Death (Check only one) Be examiner?
1 ☐ Yes 2 🛣 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 X Inpatient 2 - ER/Outpatient 3 - DOA 28a. Date of injury (Month, Day, Year) 27 Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending 1 🔀 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Division ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0062975 - Kwenhaa 110 3/14/11 WJL 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 141 thy Weishaar 400 W.7th St 32. Registrar's Signature 31. Date filed (Month, Day, Year) State MAR 1 Registrar

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For	State of Maryland / Department of Health and Mental H
State	Certificate of Death

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Physician	
/Medical	ŀ
Examiner	
	ı

Funeral Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural"; or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at once.

Baltimore, Maryland 21215-0036

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division or Vital Records, P.O. Box 68760,

1 - State Registrar	Ce	rtificate of L	R	Reg. No.						
Decedent's Name (First, Middle, Last)				2. Date of Dea		V	3. Time of Death			
Curtis Vernon Farrow				Month 03	17	Year 2011	0340	а М		
4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Dea			unty of Death				
McCready Hospital		Crisfi	e1d		Sc	merset				
5. Social Security Number 6. Sex 7. Age (In	yrs. last birthday)	If Under 1 Year	If Under 24 Hr Hours Mir		Year)	9. Birthp	place (State o	r Foreign		
215-36-0668 MM 2DF	79 Yrs.	Months Days	Hours Will	03-01-1	932	Cour	Md.			
Usual Residence of Decedent							611			
10a. State Nd. Somerset	. City, Town or Lo Westo						1 ☐ Yes			
10e. Street and Number 29401 Revells Neck Rd.		10f. Zip Code 2187	1		log. Citizer Un	of What Cou ited St	ates			
11. Marital Status 12. Was Decedent Ever Armed Forces? 12. Was Decedent Ever Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	spanic Origin? (n, Mexican, Pue Specify:	Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White, pecify:				
3 Widowed 4 Divorced Fryes, GIVE Year or Dates: 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+)	16a. Dece	dent's Usual Occupa	ition		16b. Kind	of Business/In	dustry			
(Specify only highest grade completed)		kind of work done of DO NOT use retired	uring most of w	rorking			_			
Elementary/Secondary (0-12) College (1-4or 5+)	Вос	okeeper			Ac	countin	g			
17. Father's Name (First, Middle, Last)				ame (First, Middle,	Maiden Su	ırname)				
Curtis Farrow			June	Thompson						
19a. Informant's Name/Relationship (Type. Print) Ruth Farrow Sister	19b Mail 294	ing Address (Street a)1 Revells	nd Number or I	Rural Route Numbe	ver,	own, State, Zin	? ?87 1			
20a. Method of Disposition	Ob. Place of Dispo	osition (Name of ematory or other place	71	Date		tion - City or T				
Marial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	-	od Cemeter		-20-2011	Prin	ryTand	nne			
		2. Name and Addres								
21. Signature di l'unieral Service Licensee		11673 Some		Hinman				853		
disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events a. Due to (or as a condition of the c	Due to (or as a consequence of): Due to (or as a consequence of):									
d. IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown 23c. If yes, outcome pf pr 1 □ Live birth 2 □ 4 □ Pregnant at time	Fetal death 3	□Ectopic pregnancy □ Other (specify)			230	d. Date of deliv		Year		
Part II. Other significant conditions contributing to death but no	ARTHR	ITIS	en in Part I.	23e. Did to		contribute to	the cause of o			
ACUTE RE	NAL (FAILURG		24a. Was autop	prior to completion of cause of death?					
25. Was case referred to medical examiner?				eath (Check only o	ne)					
A I Hoenital	2 ER/Outpatie	ent 3 DOA Othe	er: 4 🗆 Nursing	Home 5 ☐ Resid	ience 6 [☐Other (Spec	ify)			
27. Manner of Death 1 Natural 2 Accident 28a. Date of Injury (Month, Day Yea	ar) 28b. Time o	Worf	rat ;? Yes 2 ∐ No	28d. Describe h	ow injury o	occurred				
3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of injury building, etc. (S	At home, farm, st pecify)	treet, factory, office	(Street and Number or Rural Route Number, own, State)							
29a. Certifier (Check only one) 1 Certifying Physician: To the best of my one) 1 Medical Examiner: On the basis of examiner and manner stated.	y knowledge, dea mination and/or i	th occurred at the tin nvestigation, in my o	ne, date and pla pinion, death oc	ace, and due to the ocurred at the time,	cause(s) and manner as stated. date and place, and due to the cause(s)					
29b. Signature and title of certifier	2,	29c. License	number		29d. Date	signed (Month	, Day, Year)			
· N N +	7	D 1	18098		31	17/20	l j C			
30. Name and address of person who completed cause of death		Print) 201 F	lall H	ighuay,	Gi	field	MD 2	BIT		

Registrar

State

31. Date filed (Month, Day, Year) 1 8 201 1

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32. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar Rea. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Month Year Delbert Earl Fowler 26:15 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner ROGIONAL TEHINSULA Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Age (In yrs. last birthday **Funeral** 1**X** M 2 □ F Days Hours 485-16-6896 86 Director 10/31/1924 California Usual Residence of Decedent 28a-f show permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar mist ha matter and 10c. City, Town or Location 10d. Inside City Limits Director 1X Yes 2 ☐ No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 501 Elberta Ave. 21801 USA Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Never Married 2 Married 1 X Yes : /e Navy/ Maryland 21215-0036 1 ☐ Yes 2 X No Specify: white Specify: 3 X Widowed 4 Divorced Completed Year or Dates. Army 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Deputy Sheriff Law Enforcement Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Pearl E. Hair George L. Fowler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 1508 Windham Court, Salisbury, MD 21804 Steve M. Fowler/son Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Wicomico Memorial
Park 1 K Burial 2 Cremation 3 Removal from State 3/21/2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature ²²Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or imjury the burial-trans that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav 5 Other (specify) Pregnant a Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Steoporos. this certificate has page 2 autopsy perform Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \) Other (Specify) Hospital: 2 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred hours after death. 1 Matural 5 Pending work? 2 🗌 No Accident Investigation filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined City or Town, State) Hospital To the Hospital within 24 hours a To the Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signatu 29c. License number 29d. Date signed (Month, Day, Year,

Registrar DHMH 17 Rev 7/2009

State

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rson who completed cause of death (Item 23a) (Type, Print)

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Registrar's Signatu

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 14 Day 201 I 1:55 **P** M Betty M. Geisler Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Casey House Rockville Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 6. Sex **Funeral** 7. Age (In yrs. last birthday 8 Date of Birth Months 1 🗆 M 2 🕮 Days Min 6 Pay T925 Michigan Director 370-20-7523 85 Usual Residence of Decedent or 28a-f show 10a, State 10b, County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director DC Washington, DC 1 Yes 2 □ No 10e, Street and Number 10f. Zip Code 10g, Citizen of What Country? items 23a Funeral 1651 34 th Street 20007 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, o, 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: White Completed 3 Widowed 4 X Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Mental Hygiene. The National Cathedral 4 Administrative Assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Mental Important: If item 27 is marked any injury or other traumatic ev မှ Ruth Bache Harold Middleton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Sarah A. Geisler / Daughter</u> 2600 Tunlaw Rd. N.W. #5, Washington, D.C. 20007 20a. Method of Disposition 20b. Place of Disposition (Name of March 16, 20c. Location - City or Town, State cemetery, crematory or other place) 1 \square Burial 2 X Cremation 3 \square Removal from State 4 Donation 5 Other (Specify) 2011 Alexandria, VA Metropolitan Signature of Funeral Service Licenses 22. Name and Address of Facility DeVol Funeral Home MO1145 2222 Wisconsin Ave. N.W. Washington, D.C. 20007 23a. Part in Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Months Death Immediate Cause (Final Pinysician/ Malignancy of the Tonsils disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours airer death.

To the Funeral Director: After this certificate has been signed by the attending physician and geompleied filled in by the tunneral director, page 2 should be detached for use as the burnal-transit Exam Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2X No Month Day Year Pregnant at time of death Unknown 9 Unknown been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 XNo 1 ☐ Yes 2 ☐ No 25. Was case referred to medica Be 26. Place of Death (Check only one) Hospital 1 Yes 2X No Other: |요 1 Inpatient 2 ER/Outpatient 3 DOA 4 □ Nursing Home 5 □ Residence 6X Other (Specify) Hospice 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 1 X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3 - 14 - 2011D37142 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 1355 Piccard Dr. #100, Rockville, MD Coleman MD 31. Date filed (Month, Day, Year) 32 Registrar's Signature State MAR 17

Registrar

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			1 - State Registrar				tificate of E			Reg. No.			
I	Physicia Medic		1. Decedent's Name (First, Middle		aînes	,		2. Date of De Month	eath Day	Year 2011	3. Time of Death 7: 48 PM		
	Examin		4a. Facility Name (if not institution University of M	, give street and number)	Location of Death	0.1	4c. Cou	inty of Death	n				
	Funeral Director		5. Social Security Number 221 – 44 – 3435	8. Date of Bir (Month, Da	th 9/14/19 ! ay, Year) / 2011	9. Birth Cou	hplace (State or Foreign Intry) MD						
	nd how at	ř	Usual Residence of Decedent 10a. State 10b. County	cation					10d. Inside City Limits				
	//aryla 8a-f s tified	Director	MD Kent	-	Mill	ing:	ton					1 ☐ Yes 2🌠 No	
	a or 2 be no	١	10e. Street and Number			10f. Zip Code	_		10g. Citizen		untry?		
	th with ns 23 must	Funeral	33054 Cypress			2165			USZ				
21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	þ	11. Marital Status 1 Never Married 2 Mar Midowed 4 Divorced	iver in U.S. No	-1	Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2 🛣No		pecify Yes or No- o Rican, etc.)	Race - Amer Black, White cify: $ { m B1} $				
2-0	2 hour "natu edical	plet	15. Deceder (Specify only highe	16a	. Deced	lent's Usual Occupa	ation Juring most of wor	king	16b. Kind o	. Kind of Business Industry			
121	ithin 7 ene. r than	Completed	Elementary/Seconday (0-12)	+) M	life. DO	O <i>NOT use retired)</i> rial Ha	_	J	 Metro	o Tra	ansit		
d 2	filed w al Hygi d other event, t	Be	17. Father's Name (First, Middle, L	Last)	1 110	ace	TIGI IIG		Maiden Surname)				
ylar	Menta	욘	Thomas		Hall			Doroth	У		Marshall		
Maryland	12 should I		19a. Informant's Name/Relations		Rural Route Number, City or Town, State, Zip Code) P.O. Box 344 Millington, MI								
re,	1 and of Heal item 2	1	Sarah Johnson/Partner 20a. Method of Disposition 1									Taura Chata	
Baltimore,	Page ment c ant: If ury or		1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S		Calv	ary ch	Pentec	ostal rv 3/	28/11	Bisho	pvill	le, MD	
Balt	permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other once.		21. Signature of Funeral Service I	censee		22	Name and Addres	ss of Facility	ennie	Smith	Fune	erai Home	
			23a. Part 1. Enter the disease, or shock, or heart failure. List of	complications that caused	the death. Do						117 111	Approximate	
	hysician.	8 8	shock, or heart failure. List of Immediate Cause (Final disease or condition	only one cause on each line	Sens							Interval Between Onset and Death	
	Medical Examiner		resulting in death)	a. Due to (or as a	conse uence	of):					\neg		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a	a consequence	of):					\rightarrow		
	executed an and ial-transit	Examiner	Cause. Enter Underlying Cause (bisease or iri,jury that initiated events C.									\	
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260	icate by physics the the control of	ledic		d									
89 89	oertif ending use a	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome						23d.	Date of deli	ivery	
P.O. Box 68760	requires that the death certificate be ex been signed by the attending physician should be detached for use as the buria	Physician/Medica	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	,			Month Day Year						
P.O.	that the	y Ph	Part II. Other significant condition							obacco use co	cco use contribute to the cause of death?		
ds,	quires en sign vuld be	ted b	Atrial Fibrilla	,	ortic)	Val	ve Vege	etation	1 🗆	Yes 2 N	2 No 3 Probably 4 Unknown		
COL	law re has be e 2 sho	Completed by	Osteomyelit	ns					24a. Was auto			copsy findings available completion of cause of	
<u> </u>	Physician: The law this certificate has al director, page 2 :		25. Was case referred to medical				26 Pla	ace of Death (Che	1 🗌 Yes	2 No		2 146	
Vita	ysicia is certi directo	To Be	examiner? 1 Yes 2 No	Hospital:	ent 2 🗆 ER/O	utpatien	Othe	or.	lome 5 Resi	dence 6 🗆 C	Other (Speci	ify)	
o	ing Ph	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendin	28a. Date of injur	y 28b.	Time of injury	28c. Injury work	at ?	28d. Describe l				
sion	Attendi death ctor: A y the fi	Certificate:	2 ☐ Accident Investion 3 ☐ Suicide 6 ☐ Could	not be 28e Place of Inju	rv - At home, fa	ırm, stre		Yes 2 No	28f Location (Street and Nur	mber or Rur	ral Route Number,	
Division of Vital Records,	tal or A s after al Dire ed in b		4 ☐ Homicide determ	building, etc		-71, 511	out, idotofy, since		City or Tov		moor or man	ar rioute riamber,	
	Hospi 24 hou Funer sted fill	edical	(Check 2 Medical E	Physician: To the best of examiner: On the basis of ex	amination and/	or invest	igation, in my opinio	n, death occurred	at the time, date a	and place, and	due to the c	cause(s) and manner stated.	
	To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Luneral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the but	ž	only one) 3 Certifying 29b. Signature and title of certifier	Nurse Practioner: To the l	pest of my know	ledge, d	leath occurred at the 29c. License		ace, and due to th	e cause(s) and 29d. Date sig			
	3		Fu-Ellen	fallier,	CRN	P	Ris	31571		3/	16/6	2011	
			30. Name and address of person	who completed cause of de				- L D	1.2		M	Janal	
	m s Stat	e	31. Date filed (Month, Day, Year)	4/_	r's signature	1	eene Str	eet B	altimo	re,	Mag	yland	
	Registra	ır	MA	HEI KILL	Breeze	13	. 1						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Bedford J. Groves March 15 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Chester River Manor Kent Chestertown cial Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1 X M 2 D F Months Hours Min Director 07/31/1920 Maryland 90 213-03-4760 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 Yes 2 XNo MD Oueen Anne's Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 236 Duke of Kent Street United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, rmed Forces?

X Yes 2 \sum No Black, White, etc. by 1 Never Married 2 X Married 72 hours after Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Specify: Completed White 1943-47 event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry I Hygiene. other than "r (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 and Mental Hygie is marked other Assistant Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ <u> William B. Groves</u> Catharine R. Groves 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 i other tra Health Page 1 and 2 Hildegard Groves / Wife 236 Duke of Kent Street Chestertown, MD 21620 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) permit. Page 1 a Department of h Important: If ite 20c. Location - City or Town, State 9 1 XBurial 2 Cremation 3 Removal from State 4 Donation, 5 Other (Specify) Still Pond Cemetery 03/19/2011 Still Pond, Maryland 21. Signatur funeral Service Livins 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral 130 Speer Road Chestertown, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Chronic polmonero dostructive disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner ومعا Prio to ford a normacijanise off Sequentially list conditions, if any leading to immediate Examine cause. Enter Underlying The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran and resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death 2 No the g Unknown 9 Unknown rate has been signed by page 2 should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Erbrillytion, demention 2 No 3 Probably 4 Unknown Completed 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 1 Yes 2 No or Attending Physician: Certificate: To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) hin 24 hours after death.

the Funeral Director: After thi

npleted filled in by the funeral 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined To the Hospital o within 24 hours aff To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and tle of certi 29d. Date signed (Month, Day, Year) 2 D051735 W 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hurch Hill Road Chestertown MD 21620 Frederick 10602 32. Registal State

Registrar

State of Maryland / Department of Health and Mental Hygien ? State Registrar Certificate of Death Reg. No. Decedent's Name (First, Midgle, Last) 2. Date of Death Physician/ Month Year rman marc Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death hesterocial Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days 1 🗆 M 2 🗶 F Hours 02/06/1932 MARYLAND Director 213-28-9758 Usual Residence of Decedent or 28a-f show item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD WICOMICO OCEAN CITY 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 12605 ASSAWOMAN DRIVE UNITED STATES 21842 13. Was Decedent of Hispanic Origin? (Specify Yes or No Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed with and Mental Hygien is marked other th 12 ELECTRICAL CONTRACTING OFFICE MANAGER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ MICHAEL CLARK LOTTIE GRAIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. GARRETT GERMAN - HUSBAND 12605 ASSAWOMAN DRIVE OCEAN CITY, MARYLAND 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) CHESAPEAKE CREMATION 03/10/2011 STEVENSVILLE, MARYLAND 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND 21. Signature of Funeral Service Licens 23a. Part 1. Enter the disease, or compiler ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final GASMO Physician/ INTESTINA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Due to (or as a consequence of): resulting in death) Last burial-Physician/Medical law requires that the death certificate be Box 68760 as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? jo Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 L 9 Unknown been signed by the should be detached Unknown P.O. death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use confibute to the cause of death? Completed by Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has page 2 s autopsy performed Yes 2 death? 1 🗌 Yes of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) in 24 hours after death.

The Funeral Director; After this repleted filled in by the funeral 27. Manne f Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Division М Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the besig of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated To the 2 within 2 To the I complet 3 Cestifying Nurse Practioner: Little best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. filv one) 29b. Signature and title of ce 29c License number Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2011 Physician/ Month Henry Anthony Galczynski 16, 2154 March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City Town, or Location of Death 4c. County of Death
Carroll Carroll Hospital Center Westminster 5. Social Security Number . Age (In yrs. last birthday, If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** (Month, Day, Year)
Jan 7, 1921 1 M M 2 □ F Months Days Hours Mary land Director 90 215-16-0166 Jan Usual Residence of Decedent 28a-f show and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shor raumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** Taneytown Carroll Maryland 1 ★ Yes 2 □ No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? 21787 319 Roberts Mill Road USA Page 1 and 2 should be filed within 72 hours after death ment of Health and Mental Hygiene. 11 Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: WWII white 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) U.S. Postal Service Postal Worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Joseph Galczynski Wladyslawa Gutowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wanda G. Rhodes, sister 319 Roberts Mill Road, Taneytown, MD 21787 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1. Department of I Important: If its ■ Burial 2 □ Cremation 3 □ Removal from State injury or 3/19/2011 Dundalk, MD 4 ☐ Donation 5 ☐ Other (Specify) Holy Rosary Cemetery 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 Signature of Funeral Service Licenses any ir 23a. Part 1) Enter the disease, or complications that caused the death. Do not enter the short, or heart failure. List only one cause on such line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examine Due to (or as a consequence of): burial-trar resulting in death) Last Due to (or as a consequence of) ate has I een signed by the attending physician page 2 should be detached for use as the buria Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death
Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day g 🗌 Unknown g Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2X No 1 Yes To the Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred 1 Natural 5 Pending injury work?
1 Yes 2 No Accident
Suicide Investigation after death 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner at the time, date and place, and due to the cause(s) and 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State

Registrar

Date filed (Month, Day, Year)

Back

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Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death . 2011 Physician/ 14:52 PM 17, Edward Michael Guss March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 6980 Rooks Court / Apt. 304 Frederick Frederick Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, 1 □XM 2 □ F Months Days Hours Maryland **Director** 214-82-9287 41 May 1969 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Maryland | Frederick Frederick 10f. Zip Code 21703 10g. Citizen of What Country? 10e. Street and Number Funeral 6980 Rooks Court 7 Apt. 304 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Race - American Indian Armed Forces?

1 Yes 2X No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: Specify: Completed 3 Widowed 4 XDivorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me gines. College (1-4 or 5+) Elementary/Seconday (0-12) Teacher Public School Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Guss, Jr. Ruth Connors 19b Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8105 Coach Street, Potomac, MD 2085419a. Informant's Name/Relationship (Type, Print, Edward J. Guss, Jr./Father 20b. Place of Disposition (Name of cemetery, crematory or other place)
All Souls Cemetery 20a. Method of Disposition 20c. Location - City or Town, State 1 M Burial 2 Cremation 3 Removal from State 3/21/2011 Germantown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Stauffer Funeral Home, PA 23a. Pard Elter the disease, or o 1621 Opossumtown Pike, Frederick, MD polications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each lin Immediate Cause (Final Physiciani disease or condition resulting in death) anah Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran burial-tra Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 After this certificate 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 XYes Other: 2 🗌 No 4 Nursing Home 5 K Residence 6 Other (Specify, Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA eral Director: After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Subject 1 Yes 2/No Accident Unknown MKnown Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Nuclear City or Town, State) determined 6980 Rooks within 24 hours a Dome Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one 29b. Signature and title of certifier 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death March March Physician/ Rynold Gubisch, Jr. <u>2</u>011 16, 7:30P Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Fairland Center Silver Spring Montgomery . Social Security Number 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months May 30, 1924 Washington, 86 **Director** 578-22-6751 Usual Residence of Decedent 28a-f shor 10b. County 10c. City, Town or Location 10d. Inside City Limits items 23a or 28a-f sho ner must be notified at Director Maryland |Prince George's College Park 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9733 20740 51st Avenue United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner Armed Forces?

1 XYes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify White WWII Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 2 should be filed within 72 hand Mental Hygiene. 7 is marked other than "r Elementary/Seconday (0-12) College (1-4 or 5+) Food Distributor Auth Foods Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) John R. Gubisch, Sr. Bernadine Kelly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 shument of Health a tant: If item 27 is 1404 12th Street N. #25 Arlington, Virginia 22209 Charles S. Gubisch -son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🖄 Burial 2 🗆 Cremation 3 🗆 Removal from State MD Veterans Cemeterv 3/23/2011 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Donard V. Borgwardt Funeral Home, 21. Signature of Funeral Service License 4400 Powder Mĭll Road Beltsville. Maryland 20705 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ Atrial Fibrillation disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Con estive Heart Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last bunial attending physician for use as the buria Physician/Medical P.O. Box 68760 IF FEMALE been signed by the attendin should be detached for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 1 Live Birth
4 Pregnant
9 Unknown 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? To Be Completed by Hypertension; Hypothyroidism Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 performed? Yes 2 No 1 Yes 2 No 9 Hospital or Attending Physician: 24 hours after death. 9 Funeral Director: After this certificieted filled in by the funeral director, **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 1 ☐ Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 XNursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) injury 5 Pending 1 🗌 Yes 2 🗆 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 📃 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. To the Hosp within 24 hou To the Funer Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of March 18, 2011 R169951 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Hudson-Odoi, CRNP 15245 Shady Grove Road, #130 Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

2011

MAR 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Samuel Z. Gordon March 16,2011 Physician/ 1:08pm [™] Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Chevy Chase 5305 Saratoga Ave 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 082-14-0043 Hours (Month Day, Year) 16 1 🕱 M 2 🗆 F Days New York Aug Director Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State illed within 72 hours after death with the Maryland Director X☐ Yes 2 ☐ No MD Montgomery Chevy Chase 5 10e. Street and Number 10f Zip Code 10a. Citizen of What Country? ms 23a or must be Funeral USA 20815 5305 Saratoga Ave items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. o. þ 1 Never Married 2 X Married 1 Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me ones. Elementary/Seconday (0-12) College (1-4 or 5+) Fed Govt Judge Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Tsimkousky Berta Hyman Gordon 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5305 Saratoga Ave, Chevy Chase, MD 20815 Arline Gordon/Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date cemetery, crematory or other place) National Crematory | 3-17-2011 Falls Church, VA 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph Gawler's Sons, INC 21. Signature of Funeral Service Licensee 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ HOUR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed as the burial-transit that initiated events Due to (or as a consequence of resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23d. Date of delivery 23h. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? for Month Dav Year Pregnant at time of death 2 No signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performe Yes 2 No 2 **N**No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, examiner Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🔀 Residence 6 ☐ Other (Specify) 욘 1 Tes After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural work 5 Pending within 24 hours after death.

To the Funeral Director: Af 1 Yes 2 🗌 No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTA A SCHNETDERND 5441 MACARTHURBUD NW WASH DC 20016 31. Date filed (Month, Day, Year) Registrar's Signature State MAR 21 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Greenhalgh Miriam 2120 201 03 08 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Nicomica Peninsula Re allsburg aimal Madicul Conto Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** . Age (In yrs. last birthday) 82 Yrs. 1 □ M 2 🎛 F Days Months Hours Min 185-20-3371 Pennsylvania 0472071928 Director Usual Residence of Decedent ms 23a or 28a-f show must be notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. 10b. County 10d. Inside City Limits 10c. City, Town or Location Directo 1 Yes 2 X No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21804 USA 3001 Old Ocean City Road 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 🛣 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Examiner Black, White, etc. or, þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify white 3 X Widowed 4 Divorced Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) (unknown) Ruben Robinson Elsey 19a. Informant's Name/Relationship (Type, Pnint) Harold Greenhalgh/son 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State Zip Code) 3001 Old Ocean City Rd., Salisbury, MD 21804 Page 1 and 2 Important: If item 2 any injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H 1

Burial 2

Cremation 3

Removal from State 4 Donation 5 Other (Specify) 3/10/2011 Salisbury Crematory Salisbury, MD 21. Signature of Juneral Service License Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line terval Between Onset and Death Immediate Cause (Final Physician/ Chronic obstructive disease or condition resulting in death) prummary Medical Due to (or as a consequence of) **Examiner** Employsema Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami or Attending Physician: The law requires that the death certificate be executed the burial-transit Uresepsis that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No

9 Unknown Month Year Dav 5 Other (specify) Pregnant at time of death signed by the a d be detached for g Unknown P.O. · by · Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Records, 1 Yes 2 No 3 Probably 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 2 No page 2 s certificate of Vital 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ည 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending Division To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Af 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation the Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier сопріете Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) tazar 065222 03-09-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 100 & Carrol Street Salisbum MD 21801 +2a 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Essie C. Greene Month MANZCH 0550 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death . **Examiner** NICONICO REGIONAL SAUSBUR 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month. Dav. Year 1 □ M 2 🕱 F Months Davs Hours 222-24-3174 Director Delaware 01/20/1940 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland Director 1 Tes 2 X No Maryland Wicomico Salisbury 10f. Zip Code 10g. Citizen of What Country? 5 10e. Street and Numbe items 23a or ner must be n Funeral 21801 USA 875 Victoria Park Drive, Apt. 121 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. "natural", or item ledical Examiner r 11. Marital Status 14 Bace - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: Black Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the 1 once. the Religion Minister 12 6 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Eva Robinson Denard Palmer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 875 Victoria Park Dr., Apt. 121, Salisbury, MD21801 Kelly L. Greene/daughter 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date Eastern "Shore" other 1919 1 X Burial 2 Cremation 3 Removal from State 3/21/2011 Hurlock, MD 4 ☐ Donation 5 ☐ Other (Specify) Veterans Cemetery 22. Name and Address of Facility Stewart Funeral 821 West Road, 21. Signature of Funeral Service Ligensee Home by Holloway and Downey, P.A. Salisbury, MD 21801 Kellu 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Brain Willy Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury law requires that the death certificate be executed use as the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
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To the Funeral Director

completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 532014 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

State

MAGOSA

31. Date filed (Month, Day,

Wilford

106

32. Registrar's Signature

5+ 304 15 SAlishway MD 21804.

Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.		19a. Informant's Name/Relationship (Type, Print) Heather E. Stansbury/attorney 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zij 6200 Coastal Highway, Suite 200, Ocean Ci														
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicic completed filled in by the funeral director, page 2 should be detached for use as the but	Medical	29a. Certifier 1	Certifying	Physician: To the b	est of	my knowle	edge, death o	occured at the tim	e, date and	d place, ar	d due to the ca	ause(s) a	and manner	as state	d.	
the Hi thin 24 the Fi	Mec	only one) 3	Certifying	Nurse Practioner:	To the	best of my	knowledge, d	leath occurred at t	he time, da	te and plac	ce, and due to the	he cause	(s) and manr	ner as st		
5 <u>8 6</u> <u>8</u>		29b. Signature and t	_	u, MD				29c. Licen:	se number 100la	72	27	29d. D	ate signed (ZO []	
37		30. Name and addre	ess of person	who completed caus			23a) (Type, P	29c. Licen:								
10 ,		Daniel		CMD		107	Rac	etrack	Rd	Ber	I'm, M	U i	21811			
Stat Registra		31. Date filed (Month	h, Day, Year) MAR 1		ecistra	r's Signat	ure	land								
							- 11									

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ HOLT Month EUNICE 3:27 M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Co. General Hospital Columbia, Howard 5. Social Security Number If Under 1 Year | If Under 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days 04-28-1931 Months Hours Min. 579-40-3732 Director 79 DC Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Howard Laurel 1 😾 Yes 2 🗌 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 9105 Blues Alley, Apt. A 20723 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give 1 Yes 2 No Specify: Specify: Completed 3 Widowed 4 Divorced Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 6 t h College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Fitem 27 is marked of <u>.0</u> Cleveland Holt Frances Barbour 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20745 Frances M. Chandler/daugh. 2109 Alice Ave., Apt. 2, Oxon Hill, MD 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot cemetery, crematory or other place)
Riverdale Crem. 1 ☐ Burial 2 🏋 Cremation 3 ☐ Removal from State 03-21-2011 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, 21. Signature Funeral Service Licensee 22. Name and Address of Facility 20746 Cedar Hill FH,4111 PA Ave., Suitland, MD Part 1. Enter the disease, or complicate to the classed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 3 HOURS Immediate Cause (Final INFARCTION Physician/ MYOCARDIAL disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner THROMBOSIS 3 HOURS Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events ARTERY DISEASE law requires that the death certificate be executed CORONARY 20 YEARS Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown 4 Pregnant at time of death 9 Unknown Day 5 Other (specify) Year signed by the a d be detached f P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an his certificate has bil director, page 2 st autopsy performed? Yes 2 N Hospital or Attending Physician: The 24 hours after death.
Funeral Director: After this certificate is sted filled in by the funeral director, page 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other: 4 \(\to \) Nursing Home 5 \(\to \) Residence 6 \(\to \) Other (Specify) Hospital: ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1. Natural 5 Pending injury 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in 24 hous. the Funeral Direct 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗶 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D65567 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D. PETER JOHNSTON 4940 EASTERN AVENUE BALTIMORE. 21224 MD. 31. Date filed (Month, Day, Year) State 32. Registrar's Signat

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Registrar

MAR 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 March 2005 P ^M JAMES DEAN HODGES Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Calvert Manor Health Care Center Rising Sun 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** July 24, 1921 1 🕅 M 2 🗆 F Virginia Director 222-18-5232 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Marvland Ceci1 Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21911 United States 1881 Telegraph Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 Ϊ No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 👿 No Specify: Specify: 3 XWidowed 4 ☐ Divorced Completed White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than "r State Department life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Correctional Officer of Corrections Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edward Hubbard Hodges Myrtle Virginia Carr 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) f Health item 27 Martha Elaine Betz/Niece 195 Woods Way, Elkton, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott March 30. 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bethel Cemetery Chesapeake City, 22. Name and Address of Facility Hicks Home for Funerals, P.A. ure of Funeral Service Licensee 103 W. Stockton Street, Elkton, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Alkeroscleratio Commany Artery Onset and Death Immediate Cause (Final Physician/ years disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): -burialattending physician for use as the burial Physician/Medical Box 68760 IF FFMALE If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Day Year Pregnant at time of death Month signed by the a P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 Unknown Completed this certificate has been siral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed' 2 N Yes To the Hospital or Attending Physician: 1 within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; t Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) 2 No Other: 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pendina work?
1 Yes 2 No Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and minime as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of pertifier D0023322 buchder 5 mb 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ethigh ST, Elh. Ton MD 21921 S.S Sachder MD 126 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month March Year Physician/ Day Rita Hammond 12:00 PM Medical City, Town, or Location of Death
Perry Hall 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 5218 Forge Road Baltimore 5. Social Security Number If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Days Hours 220-01-2634 89 Vrs **Director** /14/1921 MD Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Examiner must be notified at **Funeral Director** Baltimore Perry Hall 1 🗌 Yes 2 🙀 No MD 10e. Street and Number 10f. Zip Code 9 10g. Citizen of What Country? USA items 23a 21128 5218 Forge Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black White, etc. þ "natural", or 1 Never Married 2 Married Yes 2 🙀 No 3altimore, Maryland 21215-0036 Specify: white If Yes, Give Year or Dates 1 ☐ Yes 2 😾 No Specify. Completed 3 Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) <u>administrative assistant</u> construction n and Mental Hygien 7 is marked other t 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Eleanore Marzal Page 1 and 2 should be Frank Grubowski 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Department of Health ar Important: If item 27 is any injury or other trau 1002 Saxon Hill Drive, Cockeysville, MD 21030 Donna Pruitt, daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 😾 Burial 2 🗌 Cremation 3 🗆 Removal from State cemetery, crematory or other place) Manchester MD St.Bartholomew Cem. 3/25/2011 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Ligensee Eline Funeral Home M00741 934 S. Main Street, Hampstead, MD 21074 Kenmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death End. Stage Cardiony pathy Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) Due to (or as a consequence of): resulting in death) Last sician a burial-l Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed2 death? 2 No 2 🗆 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred Natural work? 5 Pending s after death.

I Director: Af
d in by the fur 2 No Accident Investigation Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a To the Funeral C completed filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Ms Raja pahne M.D DO057 465 3/17/11 WJL

2^{†1}

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Registrar

5-203

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

N - 5 - Raya Pak & MD 2535 5m 1 h

32. Registrar's Signature

31. Date filed (Month, Day, Year)

MAR 21

Baltimore, MO. 21209

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March 17, Day 2011 Physician/ Kathryn Jean Holland 4:35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Mount Airy Kline Hospice House 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Days Hours April 28, Year 194<u>1</u> 1 M 2 XXF Maryland 69 Director 213-40-3215 Usual Residence of Decedent nit. Page 1 and 2 should be filed within 72 hours after death with the Maryland arthrent of Health and Mental Hyglene. arthrent is Health and Mental Hyglene. A shownthart. If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 □ No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21701 223 East 6th Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black White etc. 1 Never Married 2 Married ş 1 Yes If Yes, Give 2 X No Saltimore, Maryland 21215-0036 White 1 Yes 2 X No Specify. 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Clothing Factory should be filed with n and Mental Hygien 7 is marked other th Press Operator Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ludelle Mazzie Munday Walter Cecil Tucker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7703 Bridlepath Ct., Frederick, MD 21701 Dawn Solomon / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of Marchatel8. Department of H Important: If ite any injury or ot cemetery, crematory or other place)
Resthaven Crematory 1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 2011 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature I Pineral Sérvice Licensee Skkot Cody P.A. Frederick, MD 21701 Resthaven Funeral Services, 9501 Catoctin Mountain Hwy. 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Phulician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of): death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: e esn 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death sate has been signed by the apage 2 should be detached in g Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 2 No this certificate 1 Yes Be (25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 **N**o Other: 2 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: ieral Director: After filled in by the funer 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident
Suicide Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined the Hospital 24 hours a Medical 🗘 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 29b. Signature and title of certifier

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State Registrar පිව

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12

31. Date filed (Month, Day, Year)

MD-

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 12, 2011 Year Ralph Hoag 6:05 a^{M} Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** 25365 Fairway Drive Wicomico Quantico If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 1**X** M 2 □ F Months Days Hours Min. (Month, Day, Year, Country) New York **Director** 126-12-8003 89 08/27/1921 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 Yes 2 No Maryland Wicomico Quantico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 25365 Fairway Drive 21856 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status rmed Forces?

X Yes 2 \(\sum \) No Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates. Army Specify: white 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) 12 Industrial Engineer Chemical Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injuy or other traumatic event once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Ralph E. Hoaq Victoria Owen 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 25365 Fairway Drive, Quantico, MD 21856 Helga Hoag/spouse 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 🗌 Burial 2 🕱 Cremation 3 🗀 Removal from State Salisbury Crematory 3/15/2011 Salisbury, MD 4 Donation 5 Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Holloway Funeral Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ BLADDER CARCINOMA disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examiner Due to (or as a consequence or). in any, reading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death g ☐ Unknown 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CARCINOMA 1 Yes 2 Alo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsv perform death? 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year, D36576 STC nd address of person who completed cause of death (Item 23a) (Type, Print) VA WOODBROOK DR SACISBURY MO 21804 P 1665 RONALD 15 W ULTE MD 32. Registrar's Signature 31, Date filed (Month, Day, Year, Registrar

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0401 AM MAROLD 3 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL CENTER If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 🔀 M 2 🗆 F Months Hours Min 3/18/1934 220-28-0906 **Director** 76 MD Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2🔀 No MD Kent Chestertown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 7539 Sunburst Avenue 21620 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Factory Worker Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frederick Glenwood Jones Hattie Jane Graham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Jones/Wife P.O. Box 564 Chestertown, MD 21620 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Springhill Memorial3/20/11 4 Donation 5 Other (Specify) Hebron, MD 21. Signature of 22. Name and Address of Facility Bennie Smith Funeral Home neral Service Licensee Enter the dissister, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 855 High ST Chestertown, MD21620 23a. Par Enter the discusse, or complications that caused shoul, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ MEMOPTY SIS disease or condition resulting in death) DAYS Medical Due to (or as a consequence of) Examiner EMPHYSEMA Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) sician and burial-transit death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the buria Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, ASTHMA 1 Yes 2 No 3 Probably 4 Unknown Completed SOONTANEOUS PNEUMOTHORAX 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 1 XYes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Nonpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 1 Yes 2 No 2 Accident
3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) P25666 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARTIN, MD UNIVERSITY OF MARYLAND MEDICAL CENTER BALTIMORE, MD. Day, Year) 8 2011 31. Date filed (Month) 32. Re Stat-Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ^{Day} **2011** 5:13 P M March 2, Charles William Jones Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death Kent 211 Rolling Road Chestertown 9. Birthplace (State or Foreign Country) **Maryland** If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday **Funeral** Days 1 **X**M 2 □ F Hours (Month, Day, Year) .0/17/1938 **Director** 215-74-6806 Usual Residence of Decedent fshow permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene. Important; If teem 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No MD Chestertown Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Rolling Road 21620 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes X No Black, White, etc. Completed by 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Specify: 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Furniture 0 Repairman Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Mildred M. Williams Charles Henry Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21028 Chester Avenue Rock Hall, Maryland 21661 Mildred Parsons - Sister 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03/05/2011 Rock Hall, Maryland Wesley Chapel rellows, Helfenbein & Newnam Funeral Home, 1 130 Speer Road Chestertown, Maryland 21620 21. Signature of Funeral Service Licenses muca 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death: Immediate Cause (Final LUNG Ph sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hospital or Attending Physician: The law requires t 24 hours after death. Funeral Director: After this certificate has been sign 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 No 1 Tes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28c. Injury at work? 1 □ Yes 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: 1 Natural injury 5 Pending Accident 2 No Investigation 6 Could not be Suicide Location (Street and Number or Rural Route Number City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Homicide determined thin 24 hours a Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifie 58 .3 Name and address of perso ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registra State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Jewett Nancie Lee 8:16 AM 16, 2011 March Medical 4c. County of Death
Baltimore County 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** Hampstead 4607 Mount Carmel Road Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 216-24-7215 (Month, Day, Year) 1/30/1934 Country) 1 🗆 M 2 🔀 F Months Days Hours Min. 77 Director Usual Residence of Decedent 28a-f show 10a. State 10c. City, Town or Location 10d. Inside City Limits the Medical Examiner must be notified at Director Hampstead Baltimore MD1 Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? USA 21074 4607 Mount Carmel Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 Married þ 1 Yes 2 No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: white "natural" Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) per mit. Page 1 and 2 should be filed within 72 Der artment of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) own home <u>homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Nellie Boone Robertson Hartwell Macon King 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21074 a. 4607 Mount Carmel Rd., Hampstead, MD 19a. Informant's Name/Relationship (Type, Print) Sharon Jewett-Titus, daugh. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/22/2011 Hampstead, Carroll Cremation 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home - Turon M01072 934 Main St., Hampstead, S 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between
Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Exami physician and the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 ending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown for Day Year Pregnant at time of death 5 Other (specify) Month the P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 2 N 1 ☐ Yes 2 ☐ No Yes of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work Division 1 Yes 2 No Investigation 6 Could not be Accident 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of person who completed the STEPHEN LAIREN eted cause of death (Item 23a) (Type, Print), M. D. 1005 Sout H MAIN 57. HAMPSTEAD, MD, 21074

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

MAR 18

32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death March Physician/ Joseph Michael KINZER, SR. Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Washington 4b. City, Town, or Location of Death Examiner Hagerstown Meritus Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday) Hours March 6 1 🙀 M 2 🗆 F 217-12-2722 1926 Mary Tand 85 **Director** Usual Residence of Decedent or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Examiner must be notified at Director Maryland Washington Smithsburg 1 Yes 2X No 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 23a Funeral U.S.A. 21783 11834 Kieffer Funk Road items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. of Health and Mental Hygiene.
item 27 is marked other than "natural", or in other traumatic sound. ş 1 Never Married 2 Married 1 X Yes 2 No Baltimore, Maryland 21215-0036 1944 white 1 ☐ Yes 2X No Specify: Specify. 3 Widowed 4 X Divorced Completed 1945 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) freight carrier dock worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Alice Amanda Benjamin Franklin Kinzer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t. Page 1 and 2 sl tment of Health a David W. Kinzer, Jr. - son 1031 Spruce Street, Hagerstown, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State March 2011 Hagerstown, Maryland Cedar Lawn Memorial 4 ☐ Donation 5 ☐ Other (Specify) Minnich Funeral Home 21. Signature of Funeral Service Censes 22. Name and Address of Facility 415 East Wilson Blvd., Hagerstown, Maryland 21740 Part 1. Enter the disease, o complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease. Interval Between Onset and Death Immediate Cause (Final Ph sician/ ulmonary disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner 013STructive hrunc Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last the burial-transi Due to (or as a consequence of) physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 SB IF FEMALE: use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month detached for Month Day Year Pregnant at time of death Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ page 2 should be Dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy death? performed' After this certificate 1 ☐ Yes 2 ☐ No 2 Yes 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Other: 2 40 은 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner Jr eath 28b. Time of 28c. Injury at 28d. Describe how injury occurred atural 5 Pending injury s after death. 1 ☐ Yes 2 ☐ No Accident Investigation completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner To the best of high revisedge Signature and title of certifier 29d. Date signed (Month, Day, Year)

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Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) March 201 Physician/ Dorothy Lorraine Kinnamont Medical 4c, County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Meritus Medical Center Hagerstown 8. Date of Birth (Month, Day, Year) Jan. 14, 1942 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F Months Hours 69 Washington, D.C. Director 577-58-3617 Usual Residence of Deceden er than "natural", or items 23a or 28a-f shov the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location within 72 hours after death with the Maryland Director 1 Yes 2 X No MD Washington Hagerstown 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral 18630 Amanda Lane 21742 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No Black, White, etc 1 Never Married 2 Married Completed by Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates Specify: White 3 X Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) 10 th Nursing Home <u>Dietary Aid</u> Be other traumatic event, 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ၉ 2 should be William Lee Triplett Lilly May Howell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) age 1 and 2 sh int of Health ai t: If item 27 is or other trau 18618 Amanda Lane, Hagerstown, MD 21742 Lilly M. Ashworth / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1
Department of
Important: If it
any injury or o 1 XBurial 2 Cremation 3 Removal from State 03/21/2011 Williamsport, MD 4 ☐ Donation 5 ☐ Other (Specify) Greenlawn Memorial Park 22. Name and Address of Facility Gerald N. Minnich Funeral Home . Signature of Funeral Service Licensee 305 N. Potomac St., Hagerstown, MD 21740 13,4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RASPIRATORY disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner PULMOMARY CHRONIC OBSTRUCTIVE Sequentially list conditions Examine If any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 3 Ectopic pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? Month Year been signed by the atte should be detached for 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should MALLITUS CIRCINOMA LEFT 24a. Was an Were autopsy findings available prior to completion of cause of has autopsy 62E157 HYPERLIPIDEMIA 1 ☐ Yes 2 ☐ No After this certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 I DOA Certificate: To 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural injury work?
1 Yes 2 No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Com stren MARCH 18, 2011 D (8017 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MILL ST HAGERSTOWN, MOZITYO 340 DATTA MO 3H-10

Registrar
DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

MAR 2 1 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Doris Ellen KROUSE /Medical 4c. County of Death 4b. City, Town, or Location of Death Facility Name (If not institution, give street and number) Examiner Hagerstown Washington avenwood Birthplace (State or Foreign Country) If Under Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Days 1 □ M 2 🔽 F 92 Maryland Feb.24,1919 217-09-9688 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 ☐ Yes 2 ☐ No Director Hagerstown Washington Maryland 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21740 1158 Luther Drive Funeral 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐Yes 2 X If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 2 X No 1 ☐ Yes 2 X No Specify. white 3 3 ☑ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) aircraft executive secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Sarah Plummer John W. Price ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 38 Merrion Ct., Timonium, Maryland 21093 Laurel J. Cappe - daughter Date 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Rest Haven Cemetery 3/19/2011 Hagerstown, Maryland 22. Name and Address of Facility MINNICH FUNERAL HOME 21. Signature of Funeral Service Licenses 21740 E. Wilson Blvd., Hagerstown, Md. Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final 5years disease or condition resulting in death) Due to (s a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that inlitated events resulting in death) Last Due to (or as a consequence of): Examine Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tohacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ş 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 ☐ No 1 ☐Yes 200 No 25. Was case referred to medical examiner?

✓ 26. Place of Death (Check only one) Be 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1∐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 28b. Time of 1 Natural 5 Pending investigation 1 ∐Yes 2 □ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one)

The law requires that the death certificate be executed the aftending physician and hed for use as the burial-tran P.O. Box 68760, Division of Vital Records, ns certificate has been s director, page 2 should Physiclan; After this funeral (To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After filled in by the

Funeral

Director

28a-f show

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23a

items ?

9

'natural",

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygien. Important: If Item 27 is marked other the any injury or other trainment.

Physician

/Medical

Examiner

injury or other traumatic event, the Midical Exercitive quet be mitthed

Baltimore, Maryland 21215-0036

Registrar

State

29b. Signature and title of certifie

1211

29c. License number

29d. Date signed (Month, Day, Year)

null theil- Hagestown 1772 1740

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

and manner stated.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 2256 PM Betty A. King March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 E1kton Union Hospital 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🗆 M 2 🗶 F Months Days Hours Min. $J_{AN}^{(Month)} 1_{7}^{Day, Year)} 936$ Virginia 75 193-26-3267 Director Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "---10a. State 10b. County 10d. Inside City Limits 10c. City. Town or Location Director 1 Yes 2 X No E1kton Maryland Ceci1 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 21921 1800 Singerly Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Was Deceuc... Armed Forces? Yes 2 X No Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 X Divorced White 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Executive Secretary/Bookkeeper Aerospace Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ Catherine Georgie Haunshell Ancil Kelly King 19a. Informant's Name/Relationship (Type, Print) Personal Keith Davis/Representative 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Torington Way, Newark, DE 19702 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March 31. cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Oxford Cemetery 2011 Oxford. PA 21. Signative of Funeral Service Licensee 22. Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, MD 21921 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ years disease or condition Medical resulting in death) Examiner years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examiner and Due to (or as a onsequence of resulting in death) Last physician a the burial-Physician/Medical IE FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown has been signed 2 should be 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Tes Yes 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending 1 Tes 2 🗌 No

Hospital or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760 Division of Vital Records, Director: After the in by the funeral within 24 hours aft

To the Funeral Di

completed filled in

☐ Accident ☐ Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one)

29d. Date signed (Month, Day, Year) 3. 28 · 2011. 29b. Signature and title of certifier D0023322 Jaohder 8m

oleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who completed on S. S Sachdar M Type, Print) Etkich 8T, Elector MD 21921

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 1 - State Reg. No. 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March Physician/ ^{Day} 2011 17, Louise Μ. King р м Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Montgomery <u> Arden Courts Assisted Living</u> Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Feb. 23, 1923 Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country 1 M 2 TF **Director** 88 Yrs. 006-14-7379 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 X No MD Silver Spring Montgomery ò 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 2902 Regina Drive 20906 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Š 1 Never Married 2 Married White WWII 1 ☐ Yes 2 No Specify: "natural", Specify: Completed 3 Widowed 4 □ Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 Banker Banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lewis ည Louis Mahoney <u>Eva Sirois</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, $2902\ Regina\ Drive,\ Silver\ Spring,\ MD\ 20906$ 19a. Informant's Name/Relationship (Type, Print) Sandra K. Fleming/Daughter Itimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State . Page 1 1 🛣 Burial 2 □ Cremation 3 □ Removal from State March 22, It. Olivet Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Washington, DC 21. Signature of Funeral Service Licensee Name and Address of Facility and is J. Collins Funeral Home 0 University Blvd. W., Silver Inc. Spring, MD 20901 23a. Part 1. Leter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Alzheimer's Dementia disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examir burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical death certificate be IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No be detached for Month Day Year signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Ş 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law autopsy performed this certificate 2 No Yes 2 X No 1 🗌 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Assisted Living 2X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 24 hours after death. Funeral Director: Al 2 Accident
3 Suicide
4 Homicide Investigation 2 No pleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D43237 March 18, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14201 Laurel Park Drive, #102, Laurel, MD 20707 Paul Armstrong, MD

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year) NAR 21 2011

Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 12:54 am Meantrich 130a/2011 Year Physician/ Edward W. Kay Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Montgomery Bethesda Suburban Hospital Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 176-20-9885 Hours 12-18-1927 PA Country) Director Usual Residence of Decedent From "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland by Funeral Director 1 Yes 2 No Potomac Montgomery 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? USA 20854 9727 Beman Woods Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12, Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?
1 Yes 2 No 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation
(Give kind of work done during most of working
life. DO NOT use retired)
Certified Public Accountant 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry is marked other than Elementary/Seconday (0-12) Finance Be 18. Mother's Name (First, Middle, Maiden Surname)
Josephine Vidious permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) မ Frank J. Kay 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9727 Beman Woods Way, Potomac, MD 20854 Marge B. Kay/Wife 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3-18-2011 Potomac, MD 4 ☐ Donation 5 ☐ Other (Specify) St Gabriels Cem 21. Signatule of Juneral Service Lice Joseph Gawler's Sons, INC 22. Name and Address of Facility 5130 Wisconsin Ave, N.W. Washington DC 20016 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final 3 Minutes Ventricular Fibrillation Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Cardiomyopathy 1 Month Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to for as a consuluence of Mitral Valve Disease 7 Years Due to (or as a consequence of) Physician/Medical 12 Years Ischemic Heart Disease requires that the death certificate be Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Mitral Valve Repair One Month Prior to Death Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of To the Hospital or Attending Physician: The law autopsy performed? Yes 2 XNo has death? certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🏝 No Certificate: To 1 🗌 Yes 1 Inpatient 2 X ER/Outpatient 3 IDOA eral Director: After this filled it by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours arer To the Funeral Direct Medical 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗆 29b. Signature and title 29c. License number 29d. Date signed (Month, Day, Year) D07147 3/15

Registrar DHMH 17 Rev 7/2009

State

30. Name and address of person who complete

MAR 21

31. Date filed (Month, Day, Year)

大子7

cause of death (Item 23a) (Type, Print) Allen Nimetz MD 5520 Wisconsin Ave. #700 Chevy CHase, MD 20815

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 20 TI Physician/ March 6:58 Рм Ann Cecelia King Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death Examiner 4c. County of Death Frederick Frederick Frederick Memorial Hospital If Under 1 Social Security Number 6. Sex 7. Age (In vrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 212-24-5803 1 🗆 M 2 🏲 F Days Hours Min January 27, 96 1915 Maryland Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Frederick Frederick 1 X Yes 2 No 10e. Street and Number 10f, Zip Code 10g. Citizen of What Country? Funeral 187 West All Saints Street 21,701 United States of America 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Black, White, etc. Yes 2 No þ 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify Black Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working al Hygiene. I other than " life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Private Home 8 House Keeper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked of permit. Page 1 and 2 should be Department of Health and Mente Important: If item 27 is marked any injury or one. ည Charles W. Roberts Mary Blanche Dorsey þ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sandra Butler / Niece 118 South Bentz Street, Frederick, Maryland 21701 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resthaven Memorial Gardens March 28, 2011 Frederick, Maryland Name and Address of Facility
 Keeney & Bastord P.A. Funeral Home
 106 East Church Street, Frederick, Maryland 21701 M01433 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MITERY Ph. sician/ SCHRUSIS ATHERO disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** MENTIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or iinjury that initiated events resulting in death) Last executed use as the burial-transit and Due to (or as a consequence of) been signed by the attending physician should be detached for use as the burial Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 YUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy has within 24 hours after death.

To the Funeral Director: After this certificate Yes 2 No 25. Was case referred to medical filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 XNo Hospital: Other: Certificate: To 1 🔲 Yes 1 Inpatient 2 KER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury Natural 5 Pending work?
1 Yes 2 No Investigation Accident Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my color Medical 29a. Certifier completed 2 Medical Examiner: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signatu nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 4795 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2170 TREDERICK Toll House Ave MO 814 A. KAZMI

State Registrar 11-02103 Stephanie Lyles Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene 2011 10535

			1- For State Registrar				Cer	tificate d	of Dea	th				J. No.		
Med	Physicia lical Exami	ın/	1. Decedent's Nam		2. Dai Mo Ma					Dav Yea	3. Time of Death 1315 hrs					
			4a. Facility Name (i			hanie Litreet and numbe				Town, or L	ocation of		,	4c. County of		
			Prince Geo				- ,	(1) (ii) 1- X		verly	Tig i i - d	0.411 10	Date of Birth	Prince G		
	Funeral Director		5. Social Security N 579-76-4	291	6. Sex	2X F	ige (In yrs. Ia		rs. Mon	der 1 Year ths Days		T		, 1957	Foreign	
	any	ŀ	Usual Residence of 10a. State	f Decedent 10b. County			10c. City,	Town or Loc	ation						1	10d. Inside City Limits
		٦	DC								Wash	ingto	on			1 X Yes 2 No
	Maryland 28a-f show d at once.	Director	10e. Street and Nu	mber					10f. Z	ip Code				g. Citizen of Wh	at Coun	try?
	h the h			idge Ro							2001					tates
	Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumantic event, the Medical Examiner must be notified at once.	Fune	11. Marital Status 1 Never Marri Widowed		arried 1	2. Was Deceder Armed Forces 1 Yes Yes, Give Year			Yes, spe		Mexican,	in? (Specif Puerto Rica	y Yes or No- an, etc.)	14. Race White Specify:	, etc. Afr	an Indian, Black,
	urs aft tural" tmine	d by	15. Decedent's Ed		10	r Dates:	ompleted)	16a, Decede	ent's Usua	al Occupation	on (Give k			16b. Kind of Bu		rican ndustry
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	within giene.	dmo	1.2 17. Father's Name		Last\					Domes	tic	s Name (Fir	rst Middle Ma	Self aiden Surname)		loyed
	21215-0036 21215-0036 Udd be filed within 7 I Mental Hygiene. marked other than ic event, the Medica	BeC	17. Father's Name	•		s Lyles						D.	orothy	Smith		
	212 ould be d Ment s mark	10	19a. Informant's Na				_	19b. Maili	ing Addre	ss (Street	and Num	ber or Rura	I Route Numb	per, City or Town	n, State,	Zip Code) 20019
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	Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		1 X Burial 2			Removal from S	State 200. E	Hace of Disp Tellalory of Nation	al G	eme re:	PT.	March 20	1 28, 011	Landov	er,	Marvland
	Salti ermit. Separtu mporti njury		21. Signature of Fu	ine of Service	Lio nsee		SAAA	22	. Name ar	d Address	of Facility			neral Ho	me,	Inc.
	Physician	9 3	23a. Part I. Enter th	ne disease, or	complica	ations that cause	ed the death.							shingtor st, shock, or hea		Approximate Interval
	/Medical		failure. List on	lly one cause	on each											Between Onset and Death
	≛xaminer		or condition resulti		_	e to (or as a cor										
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	· Æ >Æ	by P	Part II. Other sign	ificant condi	ions co	ontributing to de	ath but not re	esulting in the	e underlyi	ng cause gi	iven in Pa	rt 1.				the cause of death? ably 4 Unknown
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	sion ttendideath.	atio	1 Natural 2 ✓ Accident	5 Pen	ding stigation			0614 hrs			es 2	No				- De de Nombre Cite
	Divis al or A s after al Direction	Certification:	3 Suicide		ld not be	28e. Place of (Specify) N				ry, office bu	uilding, etc		or Town, Sta	ate)		ral Route Number, City g Str, Washington, D
1	Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi completely filled in by the funeral director,		4 Homicide 29a. Certifier (Check only)	CertifyIng P	hysician	: To the best of	my knowled	ge, death occ	curred at t	he time, da	te and pla	ce, and due	e to the cause	e(s) and manner	as state	ed.
0)	o the l ithin 2 o the l	Medical	one) 2		miner:0	n the basis of ea	camination a	nd/or investig	gation, in i	my opinion,	death occ	curred at the	e time, date a	nd place, and d	ue to the	e cause(s)
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	S	tate	31. Date filed (Mon	nth, Day, Year)	-	32. Regist	ra's Signat		_				_	· · · · · · · · · · · · · · · · · · ·		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month ranklin March 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Hospital Center Carroll <u>Carroll</u> Westminster 8. Date of Birth (Month, Day, Year) 7/5/1926 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) **Funeral** 1 ★ M 2 □ F Days Months Hours Min. Director 84 217-20-8294 Usual Residence of Decedent MD 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Carroll Finksburg 1 🗌 Yes 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code **USA** Funeral 2609 Arabian Court 21048 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 √ Yes 2 No 1943 - If Yes, Give "natural", or 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2x No Specify. white 3 Widowed 4 Divorced 1946 Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) and 2 should be filed within 72 Health and Mental Hygiene. Iem 27 is marked other than " Pennsylvania Elementary/Seconday (0-12) College (1-4 or 5+) Railroad man Railroad Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Oliver Franklin Lowman, Sr. Margaret E. Arnold 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2609 Arabian Court, Finksburg, MD 21048 Margaret Lowman, wife injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of P
Important: If ite cemetery, crematory or other place 1 ★ Burial 2 Cremation 3 Removal from State Garrison Forest Vet. 3/23/2011 Owings Mills, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home M00741 any. S. Main Street, Hampstead, MD 21074 Lemme 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Chterococcus RUND Physician/ 49Ph disease or condition Medical resulting in death) **Examiner** nonthine wa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to for as a consequence of sician and burial-transit Due to (or as a consequence of): resulting in death) Last attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death g Unknown 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Rendi MILLER The law requires Records, 2 1 No 1 Tes 3 Probably 4 Unknown page 2 should Citeconic Kianey Disease 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No mainuted how 1 Yes 2 No or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical examiner? **Division of Vital** Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Hospital: မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after deat Funeral Director: 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Hospital Medical 29a. Certifier 1 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) 29b. Signature and title of c 29d. Date signed (Month, Day, Year) 29c. License number 031660 16/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 2011 4:06 ALFRED LABRUSH March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Frederick Memorial Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Funeral XXM 2 - F Months Davs Hours Jan 22, Year 942 Mary Tand 216-38-0849 Director Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director Maryland Frederick Frederick 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21701 USA than "natural", or items 23a Funeral 351 Catoctin Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Yes 2XX No Yes, Give 1 Never Married 2 X Married þ 72 hours after Maryland 21215-0036 1 Yes 2 No Specify. white Specify: Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. Printing machine mechanic newspaper is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Catherine Stub Alfred H. LaBrush, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau 21713 8100 Mapleville Road, Boonsboro, Maryland Paul LaBrush Brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 3-17-2011 Frederick, Maryland Stauffer Crematory 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign we of Funeral Service Icensee 22. Name and Address of Facility Stauffer Funeral Home 1621 Opossumtown Pike, Frederick, Maryland 2170 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician days 01. NO VIC disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner dia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Exami Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No the Unknown 9 Unknown ģ s been signed b should be deta 23e. Did tobacco use contribute to the cause of death? Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? this certificate Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospita Other: 1 Tes After this of funeral dire ဂ္ 1. Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c, Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending within 24 hours after death.

To the Funeral Director: Ai completed filled in by the fu 1 Yes 2 No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier 1. 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 3/15/11 170926 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Komirant MD 400 W. 75 M. 21701 31. Date filed (Month, Day, Year) egistrar's Signature State alle the Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 16, Day 2011 Year John Morgan Little 5:00 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3599 S. Leisure World Blvd Silver Spring Montgomery If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 🔀 M 2 🗌 Hours March I7, Country) 86 578-12-1345 Director 1924 D.C. Usual Residence of Decedent ms 23a or 28a-f show must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a -f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **Funeral Director** MD 1 Yes 2 No Montgomery Silver Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 3599 S. Leisure World Blvd. 20906 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 Married Yes 2 No Yes, Give 1 C Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify: r Yes, Give Year or Dates. 1941-45 3 Widowed 4 Divorced h and Mental Hygiene.
It is marked other than "natur traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Real Estate Appraiser Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ John D. Little Catherine Spruce 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebecca T. Little/Wife 3599 S. Leisure World Blvd., Silver Spring, MD 20906 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State March 18, 1 🗆 Burial 2 🖾 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) 2011 Metropolitan Crematory Alexandria, VA 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility rancis J. Collins Funeral Home Inc. 000 University Blvd. W., Silver Spring,MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or leart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Ph sician/ disease or condition Congestive Heart Failure vr. Medical resulting in death) Due to (or as a consequence of **Examiner** Pulmonary Hypertension yr. Sequentially list conditions Examine cause. Enter Underlying Cause (Disease or linjury Due to (or as a not sequence of) he Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

The law requires that the certificate has been signed by the attending physician and pleted filled in by the funeral director, page 2 should be detached for use as the burial-transparence. that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death Month Day Year Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Dementia, Atrial Fibrillation 1 ☐ Yes 2 K No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 1 Yes 2 No 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 XResidence 6 Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending iniury work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 3 Suicide
4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined Medical 29a. Certifier 🔼 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only and title of certifier 29d. Date signed (Month, Day, Year) March 17, 2011 D0012121 Name and address George F. ddress of person who complete F. Sengstack, f death (Item 23a) (Type, Print) 3929 Ferrar completed cau MD Ferrara Drive, Silver Spring, MD 20906

State

Registrar

31. Date filed (Month, Day, Year,

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JOHANNA MARGARET LINNEMANN Physician/ 22 ay 201 Year 5:30P MATR. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHARLES WALDORF CENTER GENESIS WALDORF Social Security Number If Under Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6 Sex 7. Age (In vrs. last birthday **Funeral** 76 Months Days Hours Min 5 -3 th Day 1934 1 □ M 2 🟋 320-34-8893 NEWFOUNDLAND Director Usual Residence of Decedent 28a-f show 10b County 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 10a. State 10c. City, Town or Location the Maryland Director WALDCRF 1 ☐ Yes 2 X No MD. CHARLES 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1003 SHERMAN COURT 20602 Funeral vith U.S.A. Page 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status þ 1 Never Married 2 Married Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates item 27 is marked other than "natur other traumatic event, the Medical 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health and Mental Hygiene. tem 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) AMES STORE CLERK 12th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ပ္ JOHN CROTTY ANNIE MULLINS 19a. Informant's Name/Relationship (Type, Print, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1003 SHERMAN CT • WALDORF, MD • 20602 ROBERT LINNEMANN-SPOUSE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Department of F Important: If ite any injury or ot 1 X Burial 2 Cremation 3 Removal from State MD VETERANS CEM. 3 - 30 - 11CHELTENHAM, MD. 4 Donation 5 Other (Specify) M0047 Signature of Funeral Service Licenses RAYMOND FUNERAL SERVICE, P.A PLATA, MD. 20646 nat caused the death. Do not e ter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or complication Approximate shock, or heart failure. List only one cause CAMPIONASCULAR MIS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Dire to for as a consequence of. Exami attending physician and for use as the burial-tranthat initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy

Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Month Year Other (specify) Pregnant at time of death signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Be Completed should peen 24a. Was an s certificate has b director, page 2 s autopsy perform 1 Yes 2 No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 흔 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) funeral Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred iniury Natural 5 Pending Accident Investigation by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and itle of certifie OUS UNE COUTER WASSONF, MID ZOBOX who completed cause of death (Item 23a) (Type, Print) nature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ 14. 2011 8:58 pm Edwyn Zain Mara Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Montgomery Bethesda Suburban Hospital If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours 1 X M 2 July 24 T960 washington. 219-58-7695 50 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10c. City, Town or Location with the Maryland ural", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗌 Yes 2 🗶 No Bethesda Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 20817 6002 Greentree Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Innortant: If item 27 is marked other than "natural", or items any injury or other traumatic event, the Medical Examiner mu 14. Race - American Indian Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 💆 No
If Yes, Give Black, White, etc þ 1 Never Married 2 X Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Asian 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Coventry Healthcare Underwriter Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Julian Mara Azinar Asikin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 6002 Greentree Road, Bethesda, Maryland 20817 Dewi Mara - Spouse 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Rockville, Maryland Parklawn Memorial Pk. 03/15/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 21. Signature of Funeral Service Licen ee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner 20 gequentially liet conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death 1 ☐ Yes 2 L 9 ☐ Unknown 9 Unknown the P.O. signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No **Division of Vital** Be 26. Place of Death (Check only one) npatient 2 은 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation mpleted filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) M.D., 8600 Old Georgetown Road, Bethesda, Maryland 20814 Melissa Lynn Means, 31. Date filed (Month, Day, Year)
WAR 17 2011 State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 03 2011 Wantalee Elizabeth Mayfield P^{M} 5:10 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Community Hosp Prince Georges Cheverly Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min 11-4-1943 1 \(\text{M} 2\) 67 wash., Director 577-54-9573 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director ral", or items 23a or 28a-f s Examiner must be notified MD 1X Yes 2 No Prince Georges Upper Marlboro 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 12901 20774 Cloverly Drive USA 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🛣 No If Yes, Give Maryland 21215-0036 1 Yes 2 No Specify. Black Specify: 3 Divorced 4 Divorced Year or Dates other than "natur 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Page 1 and 2 should be filed within ment of Health and Mental Hygiene. ant: If item 27 is marked other that 12 Federal Government Sup, Personnel Mgmt. Spec. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Lawrence Mary Lou Posey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
12901 Cloverly Drive
Upper Marlboro, Marvland 20774 Leroy H. Mayfield, II Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any injury or ot 1ื Burial 2 🗌 Cremation 3 🗌 Removal from State Ft.Lincoln Cem. 03-25-201 Bladensburg, MD. 4 ☐ Donation 5 ☐ Other (Specify) 윤시까6대선생약학역단세까s,II Funeral Service, P.A. 5202 PrincetonsDelightDr.,Bowle,MD20720 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as card shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury Hospital or Attending Physician: The law requires that the death certificate be executed for use as the burial-trans that initiated events Due to (or as resulting in death) Last physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month 5 Other (specify) Pregnant at time of death the a 9 Unknown g Unknown P.O. cate has been signed by page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 No 3 Probably Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No No 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred Natural 5 Pending injury after death. Investigation Accident completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) 24 hours a Funeral L Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of 29d. Date signer 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ital Dr. Cheverly, James Catevenis, MD 3001 Hospital Dr. Cheverly, Ź**ઇ**785 MD 31. Date filed (Wonth, Day, Year) 32. Registrar's Signature MAR 2 2 2011 Registrar

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	1	For State Registrar			laryland /		artment of I tificate of I	Health and N Death	Re	eg. No.	10642		
Physician Medica	/	1. Decedent's Name (F		L.	Mi	ller			2. Date of Death Day Pear 4c. County of Death				
Examine	r '	a. Facility Name (if no WMHS-		street and number)				r Location of Death Derland		y			
Funeral Director		i. Social Security Num 218-38-0	ber 6. Se	7. A	ge (In yrs. last b	irthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day Aug 2	3, 1941 9. Bird	chplace (State or Foreign untry) MD		
yland -f show ed at	. t	Usual Residence of De 10a, State 1	ob. County Alleg	10c. City, Town or Location egany LaVale							10d. Inside City Limits 1 □ x Yes 2 □ No		
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral Director	10e. Street and Numb	er				10f. Zip Code	21502	1	0g. Citizen of What Co			
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Balti permit. I Departm Importa any inju		21. Six atury of Funeral Servic Licensee 22. Name and Address of Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502											
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Detath 3. Time of Death Physician/ Month 2000 M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 211 Friendship Road Friendship Anne Arundel 5. Social Security Number . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours (Month, Day, April 16. ^{Year)} 1922 Country)
MD Director 217-40-7731 88 Usual Residence of Decedent or 28a-f show 10a. State 10b. County with the Maryland Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No MD Anne Arundel Friendship 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 211 Friendship Road 20758 USA within 72 hours after death Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🗷 No f Yes, Give "natural", or ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. Completed 3 Nidowed 4 Divorced Black Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Someone Else's Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marion Wilkerson Christine Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Christine Claggett - daughter 1228 Baliol Lane, Odenton, MD 21113 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Carters UM Church Cem. March 22, 2011 Friendship, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Sewell Funeral Home, P.A. 1451 Dares Beach Rd., Prince Frederick, MD 20678 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final set and Death Ph sician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed and the burial-tran resulting in death) Last Due to (or as a consequence of) physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IE FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 month Day Year Pregnant at time of death 5 ☐ Other (specify) as been signed by the a 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Dunknown Were autopsy findings available prior to completion of cause of death? 24a Was an this certificate has page performed 1 ☐ Yes 2 ☐ No 2 -Be 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital 2 THO 1 Tyes Other: 은 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No s after death. Accident Investigation Suicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide determined 24 hours Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print) HTF201 - 1AYLOR 32. Registra s Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 16^{Day} 2011^{Year} 8:35 P.M Sally Avril Myers Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Calvert 8451 Meadow View Circle Owings Social Security Number 6. Sex . Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 - M 2 X F Months Hours 1072071947 Michigan Director 384-50-5331 63 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland event, the Medical Examiner must be notified at Director 1 Tes 2 X No MD Calvert Owings 23a or 2 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8451 Meadow View Circle 20736 U.S.A. and Mental Hygiene. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces Š 1 Never Married 2 Married 1 Yes : Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 X Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) should be filed within finanical advisor administrative assistant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ t. Page 1 and 2 should be f tment of Heatth and Menta tant: If item 27 is marked ijury or other traumatic en Marshall Hodgson Genievieve James 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ohio 45241 Robert J. Hodgson, brother Trail Bridge, Cincinnati, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date permit. Page 1 Department of I Important: If it 1 ☐ Burlal 2 🔀 Cremation 3 ☐ Premoval from State 4 ☐ Donation 5 ☐ Other (Specify) injury Metropolitan Crematory 03/18/2011 Alexandria, VA Signate of Funeral Service 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Ancel disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Physician/Medical Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) physician and the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 9 Unknown 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 5 Other (specify) Pregnant at time of death been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Tyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy After this certificate 1 Yes 2 No 24 hours after death.
Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital: Other: 1 🗌 Yes 2 မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending iniury work? 1 ☐ Yes 2 ☐ No. Natural Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated completed (Checl Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the 1 only o 29b. Signa 29c. License number 29d. Date signed (Month, Day, Year) 065272 111111

State Registrar

DRW 1D

30. Name and address

31. Date filed (Month, Day, Year)

V.70 210

DUC-01/17

MO 21401

who completed cause of death (Item 23a) (Type, Print)

32. Registra s Signature

2003

Medic.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 2230 PM Clements Physician/ Moody Marc 201 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** River 'hostertown Center Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country) MD 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) Funeral Months Davs Hours 1/18/1935 1 🕱 M 2 🗆 F Director 217-30-8991 76 Usual Residence of Decedent 10d. Inside City Limits Strouts are more and Market Hygiene.

Is marked other than "natural", or items 23a or 28a-f shou is marked other than "natural", are items 23a or 28a-f shou raumatic event, the Medical Examiner must be notified at 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene.

tem 27 is marked other than "natural", or items 23a or 28a-f shor other traumatic event, the Medical Examiner must be notified at 10b. County Director 1 Yes 2 No MD Chestertown Kent 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 109 Lincoln Drive 21620 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Race - American Indian. Black, White, etc. Completed by 1 Never Married 2 Married ☐ Yes 2 ☐No Yes, Give Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Elbert Moody Rachel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Joyce B. Moody/ wife 109 Lincoln Drive Chestertown, MD 21620 20b. Place of Disposition (Name of Union U. M. Church Worton, MD 20c. Location - City or Town, State 20a. Method of Disposition Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/26/2011 Worton, MD 22. Name and Address of Facility 21. Signature of Fineral Service Licens Bennie Smith Funeral Home 855 High Street Chestertown, MD 21620 Part 1. Enter the disease, or complications that o shock, or heart failure. List only one cause on each used the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between and Death Respirators day Pnysician/ Medical resulting in death) 135 40 avs Examiner Sequentially list conditions Examine if any, leading to inmediate cause. Enter Underlying Cause (Disease or linjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Month Day Pregnant at time of death
Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DINType II: HTN; Atrial fibrilation 12 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No Har Prostate Concov: Covanavy Autory Disease 24a. Was an performed? Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 1 ☐ Yes 2 🗷 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 N Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Af completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 3 0050996 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ Year 9:15 P M MARCH 9. WILLIAM RUSSELL MAULE, JR. Medical 4a. Facility Name (if not institution, give street and number. 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HOSPICE CENTER OF QUEEN ANNE'S CO. CENTREVILLE OUEEN ANNE'S 8. Date of Birth Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Social Security Number 6. Sex 1 **X** M 2 □ F Days (Month, Day, Year) 08/05/1932 Min. **Director** MARYLAND 217-28-3250 78 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 XNo **OUEEN ANNE'S** MD MILLINGTON 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES **405 CHESTER RIVER HEIGHTS** 21651 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 X No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Completed Specify: 3 Widowed 4 Divorced WHITE Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 h
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "na
any injury or other traumatic event, the Medic (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 ELECTRICAL/ PLUMBING ELECTRICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည PAULINE THOMPSON WILLIAM RUSSELL MAULE, SR. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) KATHERINE M. MAULE - WIFE 405 CHESTER RIVER HEIGHTS MILLINGTON, MD 21651 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State Date 1 K Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) CRUMPTON, MARYLAND 03/13/2011 CRUMPTON_CEMETERY nature of Funeral Service Lie 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Oneet and Death shock, or heart failure. List only one Immediate Cause (Final Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence oi): To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No signed by the atte Month Dav Year 5 Other (specify) P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has perform certificate 1 Yes 4 Nursing Home 5 Residence 6 Other (Specify) TO (Q) Division of Vital within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Q.A. Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Manner of Dea h 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Natural 5 Pending work 1 Yes 2 🗌 No Accident Investigation 6 Could not be ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 10 cause of death (Item 23a) (Type, Print)

State Registrar 31. Date filed (Month, Day, Year)

32. Re

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 11 A HOLLIS MILLER, SR. 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) KENT CHESTERTOWN chester river manor 200 Morgnec If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 216-40-4097 6 Sex 7. Age (In yrs. last birthday) **Funeral** Days Hours Months **№** M 2□ F 66 Yrs. 1944 Director Usual Residence of Decedent 10d, Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 10a. State 28a-f show ral", or items 23a or 28a-f shov Exercitive mast be notified at MD Chestertown 1 ☐ Yes 2 ☐ No Kent Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2019 Pondtown Rd 21620 USA Funeral Pages 1 and 2 should be filed within 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊠Yes 2 □ No IYes, Give Year or Dates: 7 / 1 2 / 67 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: SpecifBlack ò 3 □XVidowed 4 □ Divorced "natural", Completed 16b. Kind of Business/Industry i and Mental Hygiene.
is marked other than "naturanmatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Chrysler Inc. Elementary/Secondary (0-12) College (1-4or 5+) Cars Manufacturing 18. Mother's Name (First, Middle, Maiden Surname)
Naomi Lewis 17. Father's Name (First, Middle, Last) Be James Miller ٩ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2209 Oak Glen Forestville, MD 26747 permit. Pages 1 and 2 s
Department of Health ar
Important: If item 27 is
any injury or other trau Hollis Miller, Jr.-Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place)
Emmanuel U.M. Date 20a. Method of Disposition Pomona, MD 3/9/2011 1 DBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Kenneth Walley Service 821W. St Annapolis, 21. Signature of Funeral Service Licensee Service 821W. (00026) Part 1. Enter the disease, or complications that daused the death. shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Tupell crebio Vuscula **Physician** /Medical Due to (or as a consequence of): Examiner potensive Sequentially list roadfors if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of): or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of) physician a Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 23e. Did tobacco use contribute to the cause of death? <u>چ</u> Diubetes, Chronic Renal 4 Unknown 1 ☐ Yes 2 ☐ No 3 ☐ Probably Be Completed Reval Transplants, Sever Perpheral 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an autopsy SIP Right Above the unce Amoutation axular 1 ☐ Yes 1 Tyes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1□ Yes No Certification: To 28a. Date of Injury (Month, Day, Year) 28d. Describe how injury occurred 27. Manner of Death Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 🗌 No within 24 hours after death.

To the Funeral Director: Completely filled in by the fi 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier ompleted-cause of death (Item 23a) (Type, Print) and address loud Chesteroun, MD 21620 31. Date filed (Month, Day, State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** 2:05 AM March Christopher Avyn Minor 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner The Johns Hopkins Hospital **Baltimore City** Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min. 2/28/2011 MD Director 14 n/a
Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location 1 Yes 2 No Director ms 23a or 28a-f s must be notified Shrewsbury PA York 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code USA 17361 17285 Russett Farm Drive by Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian. Black, White, etc. 1√2 Never Married 2 ☐ Married Yes 2 No Baltimore, Maryland 21215-0036 ō white 1 ☐ Yes 2 ☐ No If Yes Give Specify 3 ☐ Widowed 4 ☐ Divorced Year or Dates: "natural" Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education the Medical (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) than and Mental Hygiene n/a 7 is marked other traumatic event, th 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Christina Walter Dennis Minor ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 17285 Russett Farm Drive, Shrewsbury, PA 17361 Department of Health a Important: If item 27 is any injury or other trau Dennis Minor, father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 3/19/2011 | Reisterstown, MD Pleasant Grove Cem. 22. Name and Address of Facility Eline Funeral Home 21. Signature of Funeral Service Licensee M00741 934 S. Main St. Hampstead, Maryland 21074 Lemme Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician Severe Ventriculom /Medical Due to (or as a consequence of **Examiner** sencepha Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or injury that initiated events Zetracto The law requires that the death certificate be executed burial-trai Due to (or as a consequence of) resulting in death) Last physician is the buria Division of Vital Records, P.O. Box 68760, Physician/Medical Respiratory IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant Live birth 2 Tetal death Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 2 No 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I ş 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No or Attending Physician; 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 \(\triangle \) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 2. No 2 ER/Outpatient 3 DOA ည 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28h. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident the f Director: 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, filled in by determined 4 - Homicide City or Town, State) 24 hours a Funeral I Hospital 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 24 hor To the Fune completely fi Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only 29d. Date signed (Month, Day, Year) 29c, License number D70997 March 14 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State

Registrar

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31. Date filed (Month, Day, Year)

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32. Registrar's Signature

Chemera

600 North Wolfe St, Baltimore, MD, 21287

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ Month Erline L. Mullison 6:10 p.M March 17 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Walkersville 4c. County of Death **Examiner** Glade Valley Center Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min Feb 28 Year 916 95 Louisiana 261-09-7277 Yrs Director Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director Fairfax Virginia Vienna 1 Yes 2XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral 1700 Hicks Drive 22182 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, ral", or iter | Examiner Black, White, etc. ò 1 Never Married 2 Married white 1 Yes 2 No Specify. Specify: "natural" Completed 3XXWidowed 4 ☐ Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 t. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any injury or other traumatic event, the Mediconce. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Hugh Hiram Landry Maude Maynard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Frederick. Maryland 21702 19a. Informant's Name/Relationship (Type, Print) Gail M. Osburn - daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 3-23-2011 1 KBurial 2 Cremation 3 Removal from State Oaks, Pennsylvania Paul's Church Cemetery 4 Donation 5 Other (Specify) Signature of Funeral Service bicensee 22. Name and Address of Facility Stauffer Funeral Home 21702 1621 Opossumtown Pike, Frederick, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Heart Failure angestive Immediate Cause (Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): sate has been signed by the attending physician and page 2 should be detached for use as the burial-transit The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Dav 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? performed this certificate 2 🗆 No 1 🗌 Yes or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: Other: 1 🗌 Yes ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 X Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After the completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 🗌 Yes 2 No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral I Hospital Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check DOOG 2223

State Registrar

DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

68760

P.O.

Records,

Division of Vital

Registrar's Signature

BOLA

JM, 196 TJ DUVE, FRED EUCK, MD 21702

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 17, 2011 March 5:00a M Beverly G. Manley Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 300 Franklin Street Apt. E 53 ${ t Middletown}$ Frederick 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ept. 19, 1 □ M 2 🏻 F Months Days Hours Min. ,1938 West Virginia Director 234-56-8472 72 Sept. Usual Residence of Decedent aith and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f show r traumatic event, the Medical Examiner must be notified at 10a. State filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 ☐ No Middletown Maryland <u>Frederick</u> 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 300 Franklin Street Apt. E 53 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?
1 ☐ Yes 2 🕱 No Black, White, etc. Completed by 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 Widowed 4 X Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Florist Clerk Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental ပ Raymond F. Ewing Lillian F. Butler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. William Manley / Son 300 Franklin Street Apt.E53, Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c, Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 4 Donation 5 Other (Specify) Stauffer Crematory Inc.3/17/2011 Frederick, Maryland. 21. Signature of Funeral Septice licer 22. Name and Address of Facility
Stauffer Funeral
1621 Opossumtown Prederick, Maryland 21702 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between and Death Immediate Cause (Final Physician/ Dmall disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Pregnant at time of death 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Completed 2 No 3 Probably 4 Unknown page 2 should . Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed. 1 ☐ Yes 2 ☐ No Hospital or Attending Physician: completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No injury 5 Pending 24 hours after death. Funeral Director: A ☐ Accident ☐ Suicide Investigation
6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗌 Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who comp ed cause of death (Item 23a) (Type, Print) Street Frederick, MD ESKander 501 Elhamy Registrar's Signature back Registrar

Maryland 21215-0036

Baltimore,

Box 68760

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Physicia Medical Examin	er	Jayna Troxel M	urray					Month March 12	Day Year , 2011	0820 hrs
		4a. Facility Name (if not institution, given 4856 Bethesda Avenue	ve street and number)			4b. City, Tow Betheso	n, or Location of De la		Montgomen	/
Funeral Director		5. Social Security Number 465-83-9848 6. S	7. Ag	e (In yrs. Ia	ast birthday) Y	If Under 'Months'		_	rth(MM/DD/YYYY) 9. 2/1980	Birthplace (State or reign Country) Kansas
any	F	Usual Residence of Decedent 10a. State 10b. County		10c. City,	Town or Loc	ation				10d. Inside City Limits
Maryland 28a-f show	횽	Virginia Arlingt	on	<u> </u>		10f. Zip Co	ode	11	10g. Citizen of What C	1 Yes 2 No
eath with the Maryland items 23a or 28a-f sho ust be notified at once		1021 Arlington Bl				222	209		United Sta	ites
e e	Fune	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorce	1 Yes 2 d If Yes, Give Yeer			Yes, specify (of Hispanic Origin? Cuban, Mexican, Pu No s <i>pecify:</i>		White, etc	nerican Indian, Black, c. Vhite
ours af	ē S	15. Decedent's Education (Specify of	or Dates:	npleted)	16a. Deced	ent's Usual Oc	cupation (Give kind	of work done	16b. Kind of Busines	ss/Industry
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21215-0036 Mental Hygiene. marked other than "natural cerent, the Medical Examination of the marked other than "natural cerent, the Medical Examination.	Be Com	17. Father's Name (First, Middle, Las David Murray			30	duenc	18.Mother's N	ame (First, Middle, is Roslie	Maiden Surname)	
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Baltimore, MD permit. Pages 1 and 2 sho Department of Health and Important: If item 27 is injury or other traumati.	-	20a. Method of Disposition	ather	20b. F					20c. Location - City	
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Baltimore, permit. Pages 1 at Department of Hec (important: If ite injury or other tr	-	21. Signature of Funeral Service Lice			22	Name and Ad	dress of Facility J	oseph Gav	wler's Son ashington,	s Inc. DC 20016
Physician	-	23a. Part I. Frier the disease, or com	plications that caused	the death.						Approximate Interval Between Onset and
Vedi⊸. ≟xaminer	١	failure. List only one cause on e Immediate Cause (Final disease or condition resulting in death)	Multiple Injuries Due to (or as a cons		f):					Death
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executed an and al - transit	EXa	events resulting in death) Last	Due to (or as a cons	equence o	r): 				<u>.</u>	
O, s be exe /sician a burial -	edical	UNPENDED	AMENDED						23d. Date of deli	Nerv .
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and bempletely filled in by the funeral director, page 2 should be detached for use as the burial - transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 ✓ Unknow	23c. If yes, outco		2	Fetal death Other (Specif	3 Ectopic pre	egnancy	Month	Day Year
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S, P. quires then signe en signe	ted by				_			1Ye	es 2 V No 3 F s an 24b. Were	Probably 4 Unknown a autopsy findings available
Division of Vital Records, P.O. B within 24 hours after death. To the Hospital or Attending Physician: The law requires that the dividing 4 hours after death. To the Funeral Director: After this certificate has been signed by the bompletely filled in by the funeral director, page 2 should be detached.	Completed							auto perf 1 ✓ Yes	ppsy prior ormed? death	to completion of cause of
cian:	Be	25. Was case referred to medical examiner?	Hospital:		l =====		Place of Death (Ch		Residence 6 🗸 O	thar Coope
of Vi	၉	1 Yes 2 No 27. Manner of Death	28a. Date of In	ent 2	ER/Outpation 28b. Time		c. Injury at Work?	28d. Describe	how injury occurred	ulei. Scelle
tendin leath. tor: A	ation	1 Natural 5 Pending 2 Accident Investiga	FOUND: Day tion Mar 12, 201	1	FOUND: 0815 hrs		1 Yes 2 ✔ No			
Divis	Certification:	3 Suicide 6 Could no determin	ot be			treet, factory, o	office building, etc.		(Street and Number of State) da Avenue, Bethes	Rural Route Number, City
Divi: To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in b	Medical C	29a. Certifier 1 Certifying Physic	clan: To the best of r er:On the basis of ex- and manner stated	amination a	lge, death oc and/or investi	curred at the ti igation, in my c	me, date and place, pinion, death occur	and due to the cau	use(s) and manner as e and place, and due t	stated. to the cause(s)
\$ 1 × 1 × 1	Me	29b. Signature and title of certifier	and marginer stated				License number		29d. Date signed	
		30. Name and address of berson who	completed course	death /Itom	1 2321		O.C.M.E.		March 13, 201	
OGME			eputy Chief Med			I11 Penn S	treet, Baltimore	e, MD 21201		
St Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registr	.99	ure	ni.				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ Month 18 9:00 a^M Segundo Patrocinio Moreno March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Montgomery Rockville Shady Grove Adventist Hospital Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 13 M 2 D F Months Days Hours Min. $May^{(Month)Day, Year)}28$ 82 Peru Director 220-13-7132 Usual Residence of Decedent 28a-f shov 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at MD Germantown 1 ☐ Yes 2🏗 No Montgomery 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 13105 Twilight Court 20874 USA death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. ð 1 Never Married 2 XMarried hours after 1X□ Yes 2□ No Specify: Peruvian White If Yes, Give Year or Dates Completed 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Clerk Printing Company and Mental Hygier is marked other t Be permit. Page 1 and 2 should be filed.
Department of Health and Mental Health partment if item 27 is mediany injury or other. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Rosa Rivera Segundo Moreno 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13105 Twilight Court, Germantown, MD 20874 Maria Consuelo Moreno/Wife 20b. Place of Disposition (Name of March 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 20, 2011 4 Donation 5 Other (Specify) Metropolitan Crematory Alexandria. VA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Francis J. Collins Funeral Home Inc. MD 20901 500 University Blvd. W., Silver Spring, 23a. Part 1. Ever the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ neumonia disease or condition Medical resulting in death) Due to (or as a consequence of) 6 days Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying n and Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): attending physician a for use as the burial-Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Complete Heart Block Completed certificate has been si rector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Respiratom 11 cute autopsy performed? Yes 2 No - Cerebro Vascular 2 1 No 1 Yes Yes 25. Was case referred to medical ours after death. eral Director: After this certific filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 MNo 은 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28c. Injury at 28b. Time of 28d. Describe how injury occurred 1 Matural 5 Pending work Accident
Suicide 1 🗌 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a

To the Funeral I.

Completed filled Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier P. Mathur D35941 March 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROCKVIlle Research MD-20850 Puran Mathur 2 401 Boulevard 井ろりつ 31. Date filed (Month, Day, Year) State

Registrar

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Division of Vital Records, P.O. Box 68760

21215-0036

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Denise Edith Mister Physician/ Month 2 aM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death stal omico If Under 24 Hrs. 9. Birthplace (State or Foreign Country) Maryland 7. Age (In yrs. last birthday 53 8. Date of Birth **Funeral** 1 □ M 2 X F Days Months M2th 10-1957 216-72-3581 **Director** Usual Residence of Decedent 3a or 28a-f show t be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md. Somerset Princess Anne 1 Yes 2 No 10e. Street and Number 30550 Creek View Drive 10f. Zip Code 10g. Citizen of What Country? Funeral "natural", or items 23a edical Examiner must be 21853 United States . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Medical Examiner Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2XNo Specify: 3 № Widowed 4 □ Divorced White Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.
27 is marked other than '
traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Sales Retail Be filed 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ and 2 should be i Edith Lenora Turner Walter Henry Seifert 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Christina Lowry Health tem 27 Daughter 30550 Creek View Dr., Princess Anne, Md. 21853 permit. Page 1 and 2 Department of Healt Important: If item 2 any injury or other 1 once. 20a. Method of Disposition
1 ☐ Burial 2 Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 03-18-2011 4 ☐ Donation 5 ☐ Other (Specify) Salisbury Creamatory Salisbury, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hinman Funeral Home M00295 11673 Somerset Ave. Princess Anne. art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Irrimediate Cause (Final disease or condition Onset and Death CHRONIC Prysician/ OBSTRUCTIVE Medical resulting in death) Due to (or as a consequence of) **Examiner** ARTER ONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) I act. Examine Due to (or as a consequence of) and r burial-tran Due to (or as a consequence of): resulting in death) Last the attending physician the for use as the burial Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death Ectopic pregnancy in the past 12 months?

1 Yes 2 No

Unknown Month Pregnant at time of death 5 Other (specify) detached 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy perform 24 hours after death.

Funeral Director: After this certificate I director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 Ko Other: HOSPICIZ မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence of Other (Specify) completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one) 29b. Signature and title 29d. Date signed (Month. Day, Year) 20058410 03-17-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) mo 21804 SAKSBURG

DHMH 17 Rev 7/2009

State

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Month Physician/ MOORE SHIRLEY **EMILY** \mathbf{P}^{M} March 2011 :35 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WORCESTER BERLIN NURSING & REHAB CENTER BERLIN If Under 1 Year 9. Birthplace (State or Foreign If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Min. (Month, Day, 1 - M 2 X F Months MARY LAND Yrs Director 176-26-9435 Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director notified 1 X Yes 2 No or 28a-MARYLAND WORCESTER SNOW HILL 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number must be Completed by Funeral 23a USA 21863 204 WEST MARTIN STREET death \ or items 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Examiner Black, White, etc 1 Never Married 2 X Married within 72 hours after Specify: WHITE Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: "natural", 3 Widowed 4 Divorced Year or Dates Page 1 and 2 should be filed within 72 hours ment of Health and Mental Hygiene. tant, If item 27 is marked other than "natur lury or other traumatic event, the Medical I lury or other traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Callege (1-4 or 5+) OWN HOME HOMEMAKER 11 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ္ WHITE **EDNA** WALTER BORTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 204 WEST MARTIN ST., SNOW HILL, MD 21863 Department of Health Important; If item 27 any injury or other trong once. CLAYTON H. MOORE JR./HUSBAND 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State CREMATORY OF DELMARVA 3/17/11 DELMAR, DE 5 Other (Specify) 4 ☐ Donaxiôn 22. Name and Address of Facility of Faneral Service Licen 21. Signature HASTINGS FUNERAL HOME, SELBYVILLE, DE 19975 23a. Part 1. Enter the disease, or complications that caused the realth. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ P disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): attending physiciar Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the 38 IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 XNo Month ò 5 Other (specify) Year Pregnant at time of death detached ☐ Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 page 2 should be 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Xunknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy 2 **X**Nc 1 ☐ Yes 2 ☐ No Yes 25. Was case referred to medical 26. Place of Death (Check only one) funeral director. Be examiner? Hospital Other 2 🗶 No ၉ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ours after death.

eral Director: After this filled in by the funeral di 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. injury at Certificate: 28d. Describe how injury occurred injury 1 🗶 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number 4 Hamicide determined building, etc. (Specify) City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier A Gertifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b Signature app title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 135131 March 15, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21811 CRNP Berlin, MD Pennie Savage, 9715 Healthway DR, strar's Signature 31. Date filed (Month, 32. Req State Registrar

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OF

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ $^{Month}03$ 4:55p M 09 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death The Pines Genesis HealthCare Easton Talbot Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Country) Months Days (Month; Day, 1 №M 2 □ F Hours Min 31-32 Yrs Director -778 Usual Residence of Decedent show 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland Ħ 10c, City, Town or Location 10d, Inside City Limits Director ed other than "natural", or items 23a or 28a-f slevent, the Medical Examiner must be notified it 1 🗷 Yes 2 🗆 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No 1 Never Married 2 Married Black, White, etc. Marche, Flwood 21215-0036 1 Yes 2 No Specify. If Yes, Give Year or Dates Completed 3 Divorced 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working nd Mental Hygiene. marked other than life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, ည Health and N tem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23357 Department of Heal 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date any injury or 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place 4 ☐ Donation 5 ☐ Other (Specify) N. Smith 21. Signat re of Funeral Service Licensee Mary 22. Name and Address of Facility Accomacya 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each Immediate Cause (Final Onset and Death Physician disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events burial-tran and resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the as 1 IF FEMALE: use 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy in the past 12 months? for Month Day Other (specify) Year Pregnant at time of death 2 No the g Unknown 9 Unknown Division of Vital Records, P.O. ģ signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 2 No 3 Probably 4 Unknown Completed 1 Yes page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? Yes 2 No certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA this Nursing Home 5 🗌 Residence 6 🗍 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 2 No Accident Investigation 3 Suicide 6 🗌 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

29c. License number

29d. Date signed (Month, Day, Year) 29a. Certifier (Check 3 29b. Signature and title of certifier 3 30. Name and address of person who completed cause of teath (Item 23a) (Type, Print) Michael Crowley 610 Datchmans Lane, Easton, MD. 21601 31. Date filed (Month, Day, Year, Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician/ Kebba Ndow 3:07 pm 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Montgomery Casey Rockville House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Min. 1 🛛 M 2 🗆 F 217-33-5543 Director 42 Gambi Usual Residence of Decedent show Defaurit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Spring 1X Yes 2 No Md. Montgomery Silver 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 2200 Bear Valley Terrace 20906 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc Armed Forces 1 Never Married 2 X Married 1 Yes 2 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: black 3
Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Limosine driver Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Ousman Ndow Neneh Jallow 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) $\,20906$ 19a. Informant's Name/Relationship (Type, Print) Isatou Jallow-wife 2200 Bear Valley Terr., Silver Spring, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 N Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Washington 3/11/2011 George Adelphi, Md 22. Name and Address of Facility Universal Mortuary Signature of Funeral Service Licenses Martin 411 Kennedy St NW Washinton, DC 20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Liver Cancer Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or injury that initiated events and Due to (or as a consequence of) resulting in death) Last been signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) 1 Live Birth
4 Pregnant
9 Unknown in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Pregnant at time of death should be detached 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an this certificate has ral director, page 2: performed?

1 Yes 2 No. 1 ☐ Yes 2 ☐ No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 1 Yes 2 **X**No ပ္ 4 ☐ Nursing Home 5 ☐ Residence 6 🗷 Other (Specify) Hospice 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 Yes 2 No Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After a completed filled in by the funera 1 🔀 Natural 5 Pending Accident Investigation Sulcide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 🗷 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D37142 ss of person who completed cause of death (Item 23a) (Type, Print) Geoffrey Coleman M.D. 6001 Muncaster Mill Rd. Rockville, 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death WIWELL Physician/ EORGE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Anne Arundel Medical Center Annapolis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) Funeral 1 M 2 D F Months Days 12-18-1918 Mary Land Director 92 215-36-4978 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Director 1 ☐ Yes 2 🙀 No Anne Arundel Dunkirk 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20754 USA 6040 McKendree Road 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🎇 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes a Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: "natural", 3 🕅 Widowed 4 □ Divorced White Year or Dates traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 l Department of health and Mental Hygiene. Important: If item 27 is marked other thermany injury or other traummit. (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Farmer Agriculture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Adella Sherbert Alphonso Franklin Nutwell Julia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1834 Harbor Drive, Chester, Gloria Lee Spicer, daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 03-21-2011 Galesville, MD Woodfield Cemetery 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Rausch Funeral Home, P.A. Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between nuct ind eath Immediate Cause (Final Priysician/ disease or condition Medical resulting in death) Examiner Sequentiany list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a cons attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events Due to (or as a consequence resulting in death) Last Be Completed by Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Year Dav Pregnant at time of death signed by the a 1 ☐ Yes 2 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 № No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 this certificate has autonsy 1 Yes 2 No Yes Division of Vital or Attending Physician: within 24 hours after death.

To the Funeral Director; After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: 1 🗌 Yes မှ 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 1 Natural 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No. Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number. determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title 🎮 29c. License number who onpleted cause of death (Item 23a) (Type, Print) NTA M 445 31. Date filed (Month, Day, Year) 32. Registra s Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1 - State of Maryland / Department of Health and Mental Hygiene per me, g914,04/1372011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 20I1 10:34 P M Mary Louis Katrina Nesline Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Frederick Frederick Memorial Hospital Frederick If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jun 21, 1924 Social Security Number . Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🔀 F 579-20-4194 Washington DC Director 86 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heatlih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location Director Emmitsburg Frederick Maryland 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21727 by Funeral 333 S. Seton Avenue USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 1. Marital Status Armed Forces?
1 ☐ Yes 2 📉 No Black, White, etc 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 M No Specify: white If Yes, Give Specify: Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Religious Community College (1-4 or 5+) **5+** Elementary/Seconday (0-12) Daughters of Charity Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဥ Louis J. Nesline Carrie A. Moore 19a. Informant's Name/Relationship (Type, Print) Sister 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 So. Seton Avenue, Emmitsburg, MD 21727 Sandra Goldsborough, Servant 20c. Location - City or Town, State 20a. Method of Disposition 20b, Place of Disposition (Name of Stemete) (September place) 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 3/23/2011 Emmitsburg, MD 4 ☐ Donation 5 ☐ Other (Specify) Provincial House 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home Emmitsburg, MD 21727 210 W Main St, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician Massive disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that is the day of the cause of the cau Examine Due to (or as a consequence of) EXAMINER attending physician and I for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last APPROVED BY Due to (or as a consequence of): CERTIFICATION Physician/Medical Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) signed by the a Id be detached for 1 Yes 2 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has ral director, page 2 autopsy performe Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?

1 X Yes Hospital: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Certificate: After injury 1 Natural 5 Pending Accident death. Investigation within 24 hours after deatl To the Funeral Director: 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1. 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 10 29b. Signatur 03/21 DO035267 WJL 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick, MD Casiano MA 744 54 21701 Manuel 400 W 31. Date filed (Month, Day, Year) 32. Redistrar's Signature State

Registrar

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Box 68760, e death certificate b the attending physic of for use as the but	Pnysici		No 9 U		9 Unknow								1					11-0
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Division of Vi To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this completely filled in by the funeral di

Medical Certification: T

1 X Natural

1 X Natural	5 Pending	(Month, Day, real)		1 Yes 2 No	
2 Accident	Investigation	OO Division Alb		. affice building sta	28f. Location (Street and Number or Rural Route Number, City
3 Suicide	6 Could not be	28e. Place of Injury - At he	ome, farm, street, factor	y, office building, etc.	or Town, State)
4 Homicide	determined	(Specify)			
29a. Certifier	On the transfer of	To the heat of multipouled	an death accurred at th	e time date and place and	d due to the cause(s) and manner as stated

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)

1 Yes 2 No

111 Penn Street, Baltimore, MD 21201

March 23, 2011 O.C.M.E. 30. Name and address of person who completed cause of death (Item 233)

Assistant Medical Examiner Russell Alexander MD. 31. Date filed (Month, Day, Year) NAR 25 32. kegistrar's Signatur

1-PEND

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 16 2011 Elvia Elisa Ospino 0658 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Holy Cross Hospital Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🏝 F 88 3/105/14923 215-62-3319 CoTombia **Director** Usual Residence of Decedent 28a-f shov 10a. State 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Md Montgomery Silver Spring 1 Yes 2 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 1403 Paula Drive 20903 USA items 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ò 1 Yes 2 XNo
If Yes, Give
Year or Dates. þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 X Yes 2 □ No Specify: Colombian Sp.W.hite "natural" 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 he Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 1 2 College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Rafaela Acuna Blas Ospino 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Doris M.Ricaurte/daughter 1403 Paula Drive Silver Spring, Md 20903 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 \square Burial 2 \blacksquare Cremation 3 \square Remodal from State Chesapeake Crem. 3/21/2011 Beltsville, Md 4 Donation 5 Other (Specify) Signatur PHILIPAde RINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd.Silver Spring,Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ wks Gangrene left foot disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Peripheral vascular disease yrs Sequentially list conditions, Examiner cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) and Il-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last the burialphysician Physician/Medical Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ed by the a detached f Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ chronic kidney disease stage 3 Division of Vital Records, 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of dementia 24a. Was an page 2 s autopsy performe death? certificate 2 X No 1 Yes Yes Be 25. Was case referred to medica 26. Place of Death (Check only one) Other: 1 Yes 2 No 욘 1 Annual Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral is 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in manual transfer and the cause (s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier Barbara Suparrich, RSM, MD D 0065485 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

Barbara Supanich

MAR 21 2011

31. Date filed (Month, Day, Year)

MD

Registrar's Sign

1500 Forest Glen Drive Silver Spring, Md 20910

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Edward Lonie Outten 2011 11:26 p^M March 16, Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death **Examiner** Wicomico 507 Beaglin Park Drive Salisbury Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 6. Sex Funeral 7. Age (In yrs. last birthday) Days 1 **X** M 2 □ F Hours (Month, Day, Year) 218-16-6506 **Director** 87 0/10/1923 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location Director 1 Yes 2 X No Wicomico Salisbury Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 507 Beaglin Park Drive 21804 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify. white 3 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) owner/manager Furniture Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Myrtle M. Brittingham Chester J. Outten 19a, Informant's Name/Relationship (Type, Print) Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 507 Beaglin Park Dr., Salisbury, MD 21804 Dorothy J. Outten/spouse Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3/20/2011 Pocomoke City, MD 4 Donation 5 Other (Specify) First Baptist Cemeterý Ignature of Funeral Service Licensee Name and Address of Facility
Holloway Funeral Home Professional Association CRSP 501 Snow Hill Rd., Salisbury, MD 21804 bomprot 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one can be asked line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician, disease or condition Medical resulting in death) nsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Examine ence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been sinned by the Attending Lawrence. been signed by the attending physician and should be detached for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Day Year Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 🗆 Yes 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 💢 No Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 📈 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred injury work 5 Pending within 24 hours after death.

To the Funeral Director: Al
completed filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Signature and title IM

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2<u>011</u> Physician/ 5:35 PM 13. Mary Gaspar Prahinski March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Montgomery Suburban Hospital Bethesda Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours (Month, Day, 1 M 2 X F 166-24-7854 1927 Director 83 Usual Residence of Decedent 10a State 10b. County within 72 hours after death with the Maryland ms 23a or 28a-f shor must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No None Washington, D.C. 10e. Street and Number 10g. Citizen of What Country? Funeral 1901 Plymouth St., N.W. 20012-2211 USA ral", or items? 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 Divorced Year or Dates ed other than "natur event, the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) nd Mental Hygien marked other th Research Physiologist Medical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev John Gaspar Elizabeth Hayduk 19a. Informant's Name/Relationship (Type, Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) (daughter) Mary Christine Prahinski 1901 Plymouth St., N.W. Washington, DC 20012-2211 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place. 1 X Burial 2 Cremation 3 Removal from State March 18, 4 ☐ Donation 5 ☐ Other (Specify) Olivet Cemetery Washington, D.C. M01315 22. Name and Address of Facility DeVol Funeral Home 2222 Wisconsin Ave., N.W. Washington, DC 20007 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician, a Aspiration Pneumonia Days Medical resulting in death) Due to (or as a consequence of) Examiner Alzheimer's Disease years Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-trant Due to (or as a consequence of): resulting in death) Last IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav 5 Other (specify) Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Hepatitis C, Parkinson's, Seizure disorder 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy performed? Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) 1 ☐ Yes 2 🛛 No Hospital: Other: ျှ 1 🖾 Inpatient 2 🗆 ER/Outpatient 3 🗆 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 1 □ Yes 2 □ No 28d. Describe how injury occurred 1 X Natural injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🗵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Fractioner To the best of my knowledge dustin observed at the time, data and place, and due to the cause(s) and manner as states 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year) D21115 ennin 3/14/2011 30. Name and address of person who completed cayse of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

Lee R. Pennington,
31. Date filed (Month, Day, Year)

MAR 17

MD 10215 Fernwood Road, Bethesda, MD 20817

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene U Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 14. 2011 ar Ester Khaumovna Pilat 12:20am Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hebrew Home of Greater Washington Rockville Montaomeru . Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Ukraine 1 - M 2 X F Months Days Hours (Month, Pay, Year) 23 87 **Director** 218-35-1594 Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Me it al Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Maruland Rockville Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5525 Halpine Place, 20851 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces Black White etc. 1 Yes 2 X No
If Yes, Give
Year or Dates. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or 1 Yes 2 No Specify Specify: White Completed 3 X Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Medical Registered Nurse injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Khaum Mullerman Khaika Milshtein 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Ostrov - Daughter 748 Clifftop Drive. Gaithersburg. Maryland 20878 20b. Place of Disposition (Name of cemetery, crematory or other place)
Menorah Gardens 20a. Method of Disposition 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗎 Removal from State 03/15/2011 | Rockville, Maryland 4 ☐ Conation 5 ☐ Other (Specify)
Signature of Finesal Service License 22. Name and Address of FacilitHines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave.. Silver Spring. MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Metastutic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?

1 Yes 2 X No Month Vear 4 Pregnant at time of death 9 Unknown the hed 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Hospital or Attending Physician: The law requires 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page death? 2 🗌 No 1 Yes Yes 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 X Natural work? 1 🗆 Yes 2 🗆 No injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number 4 Homicide determined City or Town, State) Medical 29a. Certifier 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Forth 3-14-2011 Doo6 4871 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

State

Fazli

31. Date filed (Month, Day,

Montrose

Rd

Rockville,

6121

egistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 201 Tear Physician/ March₁₈ Patricia A. Porter 1842 Medical City, Town, or Location of Death Silver Spring 4a. Facility Name (if not institution, give street and number) Examiner 4c. County of Death Silver Holy Cross Hospital Montgomery 8. Date of Birth (Month, Day, Year) Dec14,1942 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Min. 1 □ M 2 😾 F 68 Months Davs Hours 577-60-9602 Director Virginia Usual Residence of Decedent or 28a-f show notified at 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland Director Montgomery Village Md. Montgomery 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 27 is marked other than "natural", or items 23a of traumatic event, the Medical Examiner must be Funeral 20886 U.S.A. 19636 Clublake Road permit. Page 1 and 2 should be filed within 72 hours after death v Department of Medith and Mental Hygiene. Important: If item 27 is marked other than "natural", or items any injury or other traumatic event. The Madical Ex 12, Was Decedent Ever in U.S. 13, Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. þ 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates SpecifyBlack 3 ₩ Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Wallace Brownlee Stertine Parham 19a. Informant's Name/Relationship (Type, Print) daughter 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20886 19636 Clublake Road Montgomery Village Md. Amanda Freeman Warren 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 11 cemetery, crematory or other place) 1 Durial 2 Cremation 3 Removal from State March₂₈, Beltsville, Md. ChesapeakeCremat. 4 ☐ Donation 5 ☐ Other (Specify) of Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility Wash Robinson Funeral Home Um Va 23a. Part . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ventricular Fibrillation Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Severe Metabolic Acidosis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Sepsis Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy page 2 should be detached for in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Dav Year Pregnant at time of death g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed' After this certificate 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director, After this certifica completed filled in by the funeral director, I To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 🔀 No 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred 1X Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 🔲 Contrying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 19, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Sami Mourad, MD 1500 Forest Glen

State Registrar 31. Date filed (Month, Day, Year)

MAR 2 2 2011

32. Regist

Road Silver Spring, Md.

11-02235 Murry Baddy Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

urry Baddy		State Registrar	of Marylar	nd / Depa	rtment	of Health of Death	and	Menta		201	1 10666
Physicia edical Examir	n/	 Decedent's Name (First, Middle,La 	Muary	Wil	lbur	Paddy			2. Date of Death Month March 22, 2	Day Year	3. Time of Death 0849 hrs
edical Examir	ier	4a. Facility Name (if not institution, gi		Paddy ber)		4b. City, To	vn, or Lo	cation of D		4c. County of Dea	
		5380 Sands Road # 59				Lothian				Anne Arunde	
Funeral		5. Social Security Number 6. S	Sex 7	. Age (in yrs. I	ast birthday) If Under Months	1 Year Days	If Under 2 Hours	4Hrs. 8. Date of Birth Min.	(MM/DD/YYYY) 9. E Fore	eign
Director		212-52-3546	∑M 2∏F	64		Yrs.	Days	Hould	02-09-	-1947 °	Country) Maryland
any		Usual Residence of Decedent 10a. State 10b. County		10c. City.	Town or Lo	ocation					10d. Inside City Limits
E			Arundel			Loth	ian				1 Yes 2 X No
Maryland 28a-f show d at once.	Director	10e. Street and Number	AI under	<u> </u>		10f. Zip C			10	g. Citizen of What Co	ountry?
15-0036 filed within 72 hours after death with the Maryland I Hygiene. dother than "natural", or items 23a or 28a-f sho t, the Medical Examiner must be notified at once.	P	# 59 Patuxent Mo	obile Est	tates		2071	1			USA	
h with	Funeral	11. Marital Status	12. Was Dece	dent Ever in U	.S. 13.	Was Decedent	of Hispa Cuban, N	anic Origin' Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Am White, etc.	erican Indian, Black,
	딢	1 X Never Married 2 Marrie	1 X Yes	2 🔲 No		Yes 2 2				Specific T 71	
rs afte ural",	盃	3 Widowed 4 Divorce 15. Decedent's Education (Specify	or Dates:			edent's Usual O			d of work done	Specify: W1 16b. Kind of Busines	nite s/industry
2 hou	eted	Elementary/Secondary (0-12)	College (1-		durir	ng most of worki	ng life. D	O NOT us	e retired)		
036 ithin 7 reference	Completed	12			Line	n Servi				Linen Se	ervice
15-0 liled w Hygie d othe		17. Father's Name (First, Middle, Las					18	_	Name (First, Middle, M		agui th
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", injury or other traumatic event, the Medical Examiner	To Be	Wilbur Norma 19a. Informant's Name/Relationship		addy	19b. Ma	ailing Address	(Street a	Loud and Numbe	LSE er or Rural Route Numi		squith ate, Zip Code)
MD id 2 shoulth and I is no 27 is numatic		Anna M. Bladen,		Repres							
Te, Tand I and Healt fitem		20a. Method of Disposition 1 Burial 2 X Cremation 3	,	20b.	Place of Di	sposition (Name or other place)	of ceme	etery,	Date	20c. Location - City	or Town, State
Pages nent of		4 Donation 5 Other Specia		Me	tropo	litan C	rema	tory	3-25-11	Alexandr	ia, VA
Baltimore, bernit. Pages I a Department of He important: If ite		21. Signature of Funeral Service Lice	ensee		- 1	22. Name and A		-	Rausch Fu		
	4	23a. Part i. Enter the disease, or con	notications that car	used the death	. Do not en	8325 Mt	dving. s	uch as care	y Lane, Own	ings, MD	20736 Approximate Interval
Physician /Medical		failure. List only one cause on	each line.								Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a			Poisoni	ще				
	۳	Sequentially list conditions, if any, leading to immediate	b Due to (or as a c	consequence (At).						
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	<u>.</u>								
ecuted and transit	I Exa	events resulting in death) Last	Due to (or as a d								
D, be exec sician a	edical					-f per	me g	g915 ———	5-4-11 vt		
ceath certificate be attending physic for use as the bur	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, o	utcome of preg rth	gnancy 2	Fetal death	3	Ectopic p	pregnancy	23d. Date of deliv Month	very Day Year
Box 6 e death cer the attendi	sicia	1 Yes 2 No 9 Unknow		ant at time of d	eath 5	Other (Speci	<i>5y)</i>				
D. B.	Phy	Part II. Other significant condition	9 011010		resulting in	the underlying	ause giv	en in Part	i. 23e. Did to	bacco use contribute	to the cause of death?
ries that to signed by I be detact	d by								1 Yes	2 ✓ No 3 ☐ F	Probably 4 Unknown
ords, v requires should	lete								24a. Was a autop		autopsy findings available to completion of cause of
teco The law ate has	Completed									med? death 2 ✓ No 1	n? Yes 2 No
tal Rection: The certificate ector, page	BeC	25. Was case referred to medical examiner?				20			heck only one)		
Physic r this c	10	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Ir	npatient 2		e of Injury 2		other at Work?	Nursing Home 5	Residence 6 O	ther: Scene
Division of Vital Records, rai or Attending Physician: The law requirers after death. a) Director: After this certificate has been sided in by the funeral director, page 2 should be	ion:	1 Natural 5 Pending	(Month,	Day, Year))815hrs		es 2 🕱 N	subject	inhaled	generator
r Atten	ficat	2 X Accident Investig 3 Suicide 6 Could n	ation 28e Place			street, factory,	office bu	ilding, etc.		Street and Number or	Rural Route Number, City
Div	Certification:	3 Suicide 6 Could n 4 Homicide determin			resid	ence			Lothia	n, Md.	inds Rd. # 59
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical (29a. Certifier (Check only one) 2 Medical Examir	er: On the basis o	of examination	dge, death and/or inve	occurred at the stigation, in my	ime, dat opinion,	e and plac death occu	e, and due to the caus urred at the time, date	se(s) and manner as s and place, and due to	stated. o the cause(s)
To Will	Mec	29b. Signature and title of certifier	and manner st	ated.				number		29d. Date signed (
		1/16	/	ND			O.C.N	I.E.		March 23, 201	1
_		30. Name and address of person wh	-			111 Page 9	treat	Baltimor	re, MD 21201		
		Russell Alexander MD. 31. Date filed (Month, Day, Year)	Assistant M	gistrar's Signa			ueet,	Daillillol	90mE		
Si Regis	tate trar	MAR 29	2011 2	recent	D. 1	parked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Betty Mae Parameros 12:33p March 11 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Carroll Dove House Hospice Westminster If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Hours Months Days 1 □ M 2 □ F 81 217-26-4730 Director 4/30/1929 MD Usual Residence of Decedent 10d. Inside City Limits 10a. State 10h. County 10c. City, Town or Location 28a-f show traumatic event, the Medical Evan from must be notified at 1 ☐ Yes 2 ▼ No Director MD Carroll Hampstead 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Numbe ō 21074 USA 1309 Paw Paw Drive 23a Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. or items 12. Was Decedent Ever in U.S. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or ite any Injury or other traumatic event, its Medical Exert. 1 ∐Yes 2 MNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐Yes 2√2 No Specify: white þ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Catherine Hannah Edward C. Getzler ဥ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1309 Paw Paw Drive, Hampstead, MD 21074 Michael Parameros, husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 3/18/2011 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Owings Mills, MD Garrison Forest Veterans 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Eline Funeral Home △ M00741 _d 934 S. Main St., Hampstead, MD 21074 emmer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death LUNG CARCINOMA Immediate Cause (Final **Physician** NONSMALL disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physiclan: The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Year Month Day in the past 12 months? 4 ☐ Pregnant at time of death P.O. 1 TYPS 2 NO 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) DOVE HOUSE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? After t 1 ■ Natural 2 ■ Accident 5 Pending investigation within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and time of confiden 29d. Date signed (Month, Day, Year) 29c. License number WJL WJL 120059552 ort 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POOLERD WESTMINSTER GOURISHANKAR C NAGANNA 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

ORIGINAL

11-02259	
Gregory Pierce	

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Gregory Pierce	Registrar	artment of ertificate of		Mental Hy		g. No. 2011	10668
Physician Medical Examine					 Date of Death Month March 23, 	Day Year	3. Time of Death 0424 hrs
	4a. Facility Name (if not institution, give street and number) 13801 Coastal Highway	4	b. City, Town, or Loc Ocean City	cation of Death		4c. County of Death Worcester	1
Funeral Director	5. Social Security Number 217-96-1298 6. Sex 7. Age (In yrs. 1 1 1 M 2 F 46	last birthday) Yrs.	If Under 1 Year	If Under 24Hrs. Hours Min.	1	h(MM/DD/YYYY) 9. Bir 13,1964 Foreig	
yne	Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Location	on				10d. Inside City Limits
₫	Maryland Worcester	Berlin					1 Yes 2 No
the Maryland nor 28a-f show iffed at once.	10e. Street and Number 20 Moonraker Road		10f. Zip Code 21811			og. Citizen of What Cou Jnited Stat	
or items 23		lf Y∈	s Decedent of Hispar es, specify Cuban, M	exican, Puerto F		White, etc.	ican Indian, Black,
5-0036 led within 72 hours after bygiene. after than "natural", the Medical Examiner	l or Dates:	16a. Decedent	's Usual Occupation ost of working life. DO	(Give kind of wo		16b. Kind of Business/	
5-0036 ed within 72 hour lygiene. in ther than "natur he Medical Exan	12	Mainte		gineer		Hote1	
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than ic event, the Medical				Mother's Name (Annie F		faiden Surname)	
MD 21 d 2 should th and Me th and Me a 27 is ma tumatic ev	19a. Informant's Name/Relationship (Type, Print) Annie F. Pierce (Mother)		Address (Street ar onraker R			ber, City or Town, State D 21811	e, Zip Code)
F E E B	1 X Burial 2 Cremation 3 Removal from State	crematory or oth	eaven Cem.	Mar 20		20c. Location - City or Silver Sp:	
Baltimore permit. Pages 1 Department of 1 Important: If injury in rather	21. Signature of Funeral Service Linsee M01116	5 10	ame and Address of East Dee	Facility DeV	ol Fune Dr. Gai	ral Home thersburg,	MD 20877
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death failure. List only one cause on each line.						Approximate Interval Between Onset and
xaminer	Immediate Cause (Final disease or condition resulting in death) a. Multiple Is Due to (or as a consequence of the condition						Death
ed nsit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	of):					
d d ansit		of):					
50, te be executed tysician and burial - transit	▼ UNPENDED	,28a-f p	er ₆₋₂₄ 291	4 4-15-	ll vt		
OX 6871 Bath certifica attending plot use as the certifical cortion of the certifical c	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown	gnancy 2 Fet		Ectopic pregnar		23d. Date of deliver Month	y Day Year
P.O. B. ss that the de gned by the e detached f		resulting in the u	nderlying cause give	n in Part I.		bacco use contribute to	
ords, P w requires the special points of the					1 Yes		utopsy findings available
Division of Vital Records, tal in Attending Physician: The law require is after death. al Director: After this certificate has been signed in by the funeral director, page 2 should be partification: To Be Commission.			OC Plans of	Dooth (Charles	autop perfor 1 Yes	med? death?	completion of cause of es 2 No
Vital yysician yysician directol	examiner? Hospital: 4 Investigat 2	ER/Outpatient		Death (Check o		Residence 6 🗹 Othe	er: Scene
nding Ph th.:: After t e funcral	27. Manner of Death 1 Natural 5 Pending 28a. Date of Injury (Maph) Day, Year)	28b. Time of Ir	1 No.			now injury occurred fell throu	gh a window
ivisi nr Att after de Direct lin by	2 X Accident Investigation 3 Suicide 6 Could not be determined (Specify) hote	_	.m	ding, etc.	28f. Location (S or Town, S	Street and Number or R	ural Route Number, City astal Hgwy.
the Ho hin 24 h the Fun npletely	1 29a. Centiler .			and place, and	due to the caus	e(s) and manner as sta	
2-PUND	29b. Signature and title of certifier	(29c. License n O.C.M.			29d. Date signed (Mo	onth, Day,Year)
	30 Name and address of person who completed cause of death (Iten Zabiullah Ali, M.D. Assistant Medical Examine	,	n Street, Baltim	ore. MD 212	201	1	
Stat Registra	31 Date filed (Month, Day, Year) 32. Registrar's Signat						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Jean Price Phillips 11,50 M Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner HICO MICO odiese 344156414 ROGIONAL TENINSULA If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Security Number 7. Age (In vrs. last birthday) **Funeral** 1 □ M 2 🕱 F Min. Hours 03/701 /1/9/20 Maryland 216-16-7353 91 Yrs **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Wicomico Salisbury 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral 227 Canal Park Drive 21804 USA items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. 0 ģ 1 Never Married 2 Married Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 K No Specify: Specify: white "natural", Completed 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 }
Department of Health and Mental Hygiene.
Important: If fem 27 is marked other than "na any injury or other traumatic event". (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) housewife domestic Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ John Arthur Price Gertrude Blades 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John Phillips/son 508 Park Ave., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 K Cremation 3 Removal from State Salisbury Crematory 3 | 16 | 2011 Salisbury, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses Thomay Funeral Home Professional Association 16x4 10 501 Snow Hill Rd., Salisbury, MD 21804 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate erval Betweer Onset and Death Immediate Cause (Final Physician/ Myocardial disease or condition resulting in death) Acute Medical Due to (or as a consequence of) Examiner Congestive heart Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) inding physician and use as the burial-transit that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Box 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death 1 ☐ Yes 2 ¥ 9 ☐ Unknown g Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an The law has autopsy pade performed? Yes 2 X No 1 Yes 2 No certificate Hospital or Attending Physician: **Division of Vital** funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 XNo Other: 1 Yes ပ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred To the Hospital or Attenuers within 24 hours after death.

To the Funeral Director: After the Funeral Director After the funeral properties of the funeral properties. injury 1 X Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 068222 03-14-11

State

DHMH 17 Rev 7/2009

Registrar

CARNOLL ST. SALISBURY Md. 21801

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

MAR 18 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Ø Month Physician/ 23:44 2011 500 1 Mac Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 31Daur madical conta Wicomica earmal If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Months Director Usual Residence of Dece Show 10a. State 10d. Inside City Limits 10c. City. Town or Location death with the Maryland notified at Director 28a-f 1 Yes 2 I No 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code ms 23a or must be r Funeral 3 9 9 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian. 11. Marital Status Armed Forces?

1 Yes 2 No Examiner Black, White, etc. 1 Never Married 2 Married 5 þ Baltimore, Maryland 21215-0036 filed within 72 hours after 2 X No Specify. If Yes, Give Year or Dates 1 Yes "natura!", 3 Widowed 4 Divorced Completed ac the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry than Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the Nonce. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Page 1 and 2 should be 1 nent of Health and Menta 19a. Informant's Name/Relationship (Type, Print) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location or Town, State Date cemetery, crematory or other Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Signature of Ameral Service Licenses 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. A proximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Due to (or as a consequence of) Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to for as a consequence of, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events The law requires that the death certificate be executed and the burial-tran Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Records, P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Live Birth 2 ☐ required
☐ Pregnant at time of death
☐ Unknown 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) in the past 12 months? Month Day Year as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has page performe Yes 2 No 2 No 1 Tes Division of Vital Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 X Ño 2 ER/Outpatient 3 DOA မှ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work 2 No Investigation Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier ss of person who completed cause of death (Item 23a) (Type, Print) 30. Name and addre EKLV

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year,

MAK

32

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) Month March 24, 2011 Physician/ 6:35 A. M Robert D. Peloguin Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Somerford House & Place Frederick 9. Birthplace (State or Foreign MA^{Country)} f Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday) **Funeral** 1 **X** M 2 □ F Days Hours January 9 1929 82 Yrs 032-18-1936 Director Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 ¥ Yes 2 □ No Broward Plantation FL10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral USA 33325 400 NW 127th Avenue 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No
If Yes, Give 1051-10 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. rr Yes, Give Year or Dates, **1951-195**5 white 3 Divorced 4 Divorced Completed 16a Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other that any injury or other traumatic event, the Mones. Elementary/Seconday (0-12) 12 Justice Dept. Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Loreto Harper Charles Peloquin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 400 NW 127th Avenue Plantation, FL 33325 Margaret S. Peloquin / wife 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Smithsburg Crematorium 1 Burial 2 🔀 Cremation 3 🗆 Removal from State :03-27-2011 Smithsburg, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility ure of Funeral Ser J. L. Davis Funeral Home 12525 Bradbury Avenue Smithsburg, Maryland 21783 Par 1 Ener the osease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Immediate Cause (Final Physician/ Acute disease or condition resulting in death) Medical Examiner Sequentially list conditions Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury attending physician and I for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate bewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months? Year Month Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown 9 Hinknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown DIOBETCS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' To the Funeral Director: After this certificate I completed filled in by the funeral director, page 2 No 1 🗌 Yes 1 ☐ Yes 2 🗷 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 🔀 No Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) HasistAd 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred injury 1 X Natural 5 Pending Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1🔏 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier D51643 Shop mo 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) hon Registrar

			State of Maryland / Dep				10072	
		•		ertificate of Death		g. No.	10672	
	Physicia Medic		Decedent's Name (First, Middle, Last) CATHERINE ANN PAWLUKANIS		2. Date of Death Month MAR . 24		3. Time of Death 6:10A M	
	Examir		4a. Facility Name (if not institution, give street and number) 18784 WICOMICO RIVER DRIVE	4b. City, Town, or Location of Death COBB ISLAN	TD.	4c. County of Death		
7	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	8. Date of Birth	CHARLES 9. Birth	place (State or Foreign		
	Director		188-05-4968	Months Days Hours Min.	1-23-19	19 PA.	try)	
	Maryland 28a-f sho otified at	Director		DBB ISLAND		1	0d. Inside City Limits 1 ☐ Yes 2X No	
	with the s 23a or	Funeral D	10e. Street and Number 18784 WICOMICO RIVER DRIVE	10f. Zip Code 20625	1	g. Citizen of What Cour $U_{ullet}S_{ullet}A_{ullet}$	ntry?	
9036	is filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	11. Marital Status 1 Never Married 2 Married 3 Widowed 4 Divorced Divorced 12. Was Decedent Ever in U.S. Armed Forces? 1 NAVY If Yes, Give Year or Dates. WWII	Was Decedent of Hispanic Origin? (Spelf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 XNo Specify:	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify: WHI	etc.	
21215-0036	within 72 hou giene. er than "natu the Medical	Completed	(Specify only highest grade completed) (Give Elementary/Seconday (0-12) College (1-4 or 5+)	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) EECRETARY	ing	DEPT. OF U.S.GOVT	ARMY	
73	should be filed vand Mental Hyg 7 is marked othe raumatic event,	To Be	17. Father's Name (First, Middle, Last) MAR'TIN PAWLUKANIS	18. Mother's Nam HELEN	e (First, Middle, Maid I BOGDAN	First, Middle, Maiden Surname) BOGDAN		
	age 1 and 2 should be int of Health and Ments t; If item 27 is marked y or other traumatic e		I = u = u = u	ing Address (Street and Number or Rura 84 WICOMICO RIV			Code) LAND, MD. 2	
nore	ige 1 an nt of He t; If iten 7 or oth		20a. Method of Disposition 20b. Place of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, cre	osition (Name of grant of the place)	Date 20	c. Location - City or To		
Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or ot		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee MO 0 4 79	AN CREMATORY 3- 2. Name and Address of Facility RAYMOND FUNERAL LA PLATA, MARYLA	SERVIC	LEX.,VA. E,P.A.		
	hysician/ Medical Examiner	ər	23a. Part 1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Due to (or as a consequence of):	ter the mode of dying, such as cardiac o		-	Approximate Interval Between Onset and Death	
09/	ate be executed physician and the burial-transit	edical Examiner						
. Box 6876(To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the			☐ Ectopic pregnancy ☐ Other (specify)		23d. Date of delive Month	ery Day Year	
ds, P.C	quires that ten signed bould be deta	<u>ا ۾</u> ا	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.		cco use contribute to th	ne cause of death?	
Division of Vital Records, P.O.	an: The law re tificate has be tor, page 2 sho	Be Completed	25. Was case referred to medical	26. Place of Death (Check	24a. Was an autopsy performed 1 Yes 2	prior to col death?	osy findings available mpletion of cause of	
f Vita	Physici this cer al direc	은	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatie 27. Manner of Death 28a. Date of injury 28b. Time of	nt 3 DOA Other: 4 Nursing Ho	me 5 Residence	e 6 🗆 Other (Specify,)	
o uc	nding ath. r: After ie funer	icate	1 Natural 5 ☐ Pending (Month, Day, Year) injury 2 ☐ Accident Investigation	28c. Injury at work? M 1 ☐ Yes 2 ☐ No	28d. Describe how i	njury occurred		
Division	tal or Atters after de al Directo ed in by the	Il Certificate:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Stree City or Town, S	t and Number or Rural tate)	Route Number,	
	e Hospit 24 hou e Funera	Medical	29a. Certifier (Check only one) Certifying Physician: To the best of my knowledge, death of the	stigation, in my opinion, death occurred at	the time, date and p	lace, and due to the cau	use(s) and manner stated.	
	To the within to the comp		29b. Signature and title of certific	29c. License number		Date signed (Month, L		
	341		30. Name and add ss of person who completed cause of death (Item 23a) (Type, Howard That The 100, 1270 01)	Print) NY CANTER MY	NACE	M DEAL	7	
ı	Stat Registra	.0	31. Date filed (Month, Day, Year) APR 0 1 2011 32. Registrar's Signature	The College	7.70	200		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Michael Francis Passarell Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Allegany Cumberland Western MD Regional Medical Center Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 02-21-1937 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Hours 1 🔀 M 2 🗆 F Mary Land Director 74 215-34-4985 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits the Maryland Director 1 Yes 2 No Cresaptown Allegany 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral U.S.A. 21502 within 72 hours after death with 14725 Oakwood Street 12. Was Decedent Ever in U.S. Armed Forces? 055 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Maryland 21215-0036 1958 1 Yes 2 No Specify: If Yes, Give White 3 Widowed 4 Divorced Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Conductor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname Genevieve Mire Passarell Michael W. Passarell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14725 Oakwood Street Cresaptown, MD 21502 Helen Passarell Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Cumberland Crematory: 3-28-11 Cumberland, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Sowers Funeral Home. Sowers MO0 547 Main Street Frostburg, MD 21532 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final A CUTEMYOCAR NFARCTION Physician/ disease or condition resulting in death) Medical Examiner DISEASE CORUNA Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of and use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant
9 Unknown Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚾 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy this certificate has page 2 2 10 No **Division of Vital** director. 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) 2 No 1 Yes Certificate: To 1 Polnpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 24 hours after death. Funeral Director: After 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation Accident Suicide 6 Could not be 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed To the I within 2. 29b. Signature and title of certifier 29c. License numbe

101

Registrar
DHMH 17 Rev 7/2009

State

ame and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

02690

925Bishop Wolsh Rd Cumberland MD 21502

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 2011 Robert Ellsworth Rhoades March 04:06AMM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Union Hospital of Cecil County E1kton Ceci1 9. Birthplace (State or Foreign Country), Elkton Maryland Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 6. Sex **Funeral** Days Min 1 XM 2 F Months Hours Yrs. Director 1948 <u> 220-50-2117</u> Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "note". 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 No Maryland Cecil Rising Sun 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 121 Bard Cameron Road 21911 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 □ Xyes 2 □ No If Yes, Give US Marine Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married 1 ☐ Yes 2 XNo Specify: White Specify: 3 🗌 Widowed 4 🗆 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Laborer Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည William C. Rhoades Eurma Garten 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary E. Ewing / Sister 367 Nottingham Road, Elkton, Maryland 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Marchate19. 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Maverdale Crematorv 2011 Newark, Delaware Signature of Funeral Service Cen 22. Name and Address of Facility Crouch Funeral Home, P.A. 127 South Main Street, North East, Maryland21901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Betwee Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Backerema Medical Due to (or as a consequence of) Examiner Secretariolly list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of): attending physician and I for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Dirett Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for Month Pregnant at time of death 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 4 Unknown thatits C Completed 1 Yes 2 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? Alco Wither 24a. Was an I **Director:** After this certificate has I d in by the funeral director, page 2 s autopsy COPD 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 2 🗷 No မ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 28a. Date of injury (Month, Day, Year) Manner of Death

Natural

Accident Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 ☐ Suicide 4 ☐ Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours after

To the Funeral Direct

completed filled in by 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D6 49 On cee wa 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Mei 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death ^{Day} 2011 Month Physician/ 12:44 Рм Marie Huber Rhue March 16 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Prince George's Hospital Cheverly Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav Funeral Months Days Hours (Month Day, 1 □ M 2 🖾 F 577-10-8748 98 Yrs Hyattsville, MD Director Usual Residence of Decedent 23a or 28a-f show ust be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 X Yes 2 ☐ No Maryland Prince George's Cheverly 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral must 5613 Greenleaf Road 20785 IISA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status "natural", or iten edical Examiner r Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed Medical Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 73 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 8 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Johanna Boem Karl Huber 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 157 Hunting Ridge Circle, Rock Spring, GA 30739 Earl C. Rhue / Son 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State cemetery, crematory or other place) 3/18/2011 Alexandria, Virginia Metropolitan Crematory 4 Donation 5 Other (Specify) 21. Signature of Furjeral Service kicensee 22. Name and Address of Facility 4739 Baltimore Avenue Hyattsville, MD 20781 Gasch's Funeral Home, P.A. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or Examiner Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immediate or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events burial-tran and Due to (or as a consequence of) resulting in death) Last physiciar Physician/Medical Division of Vital Records, P.O. Box 68760 the as attending IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? ó 5 Other (specify) Month Day Year Pregnant at time of death detached the signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? page 2 autopsy perform certificate 1 Yes 2 No Yes 2 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes ပ္ After this filled in by the funeral Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at (Month, Day, Year) Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier completed Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month Day, Year)

State Registrar

DHMH 17 Rev 7/2009

Dametrios James Catevenis, 3001 Hospital Drive, Cheverly, MD 20785

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's

31. Date filed (Month, Day, Year)

MAR 2 2 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ 2:10 PM WILLIAM AUGUSTUS REINBURG Medical ation of Death 4a. Facility Name (if not institution, give street and number, 4c. County of Death 4b. City, Town, or L **Examiner** La Birthplace (State or Foreign Country)
 C If Under 1 Year | If Under 24 Hrs. Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral (Month, Day, 0-23-Hours 1 🛛 M 2 🗆 F 577-36-3951 DC 82 Director Usual Residence of Decedent show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at Director 1X Yes 2 □ No White Plains MD Charles 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Completed by Funeral 20695 USA 9265 Crain Highway 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes If Yes, Give 2**X** No 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) Private Industry Sheet Metal Mechanic Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Maryland ျ Margaret MacInnis Earl J. Reinburg 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2431 Old Washington Rd., Waldorf, MD 20601 David Roberts, Jr./friend Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State Suitland, Maryland 03 - 22 - 2011Cedar Hill Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service License 22. Name and Address of Facility Cedar Hill FH,4111 PA Ave.,Suitland, MD Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying such as cardiac or respiratory argest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner NEWHORE Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or liniury use as the burial-tran and that initiated events Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 5 Other (specify) Pregnant at time of death 2 🗌 No the a 9 Unknown 9 Unknown been signed by t should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 🗌 Yes 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? page 2 s autopsy performed's 1 Yes 2 No 25. Was case referred to medical examiner? within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 26. Place of Death (Check only one) æ 2 Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 2 ER/Outpatient 3 DOA npatient 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Accident
Suicide Investigation
6
Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29d. Date signed (Month, Day, 31. Date filed (Month, Day, Year) State MAR 2 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** /Medical 4b. City, Town, or Location of Death BEACH 4c. County of Death 4a. Facility Name (If not institution, give street and number, **Examiner** CHESAPEAKE CALVERT LAND WOOD If Under 1 Year | If Under 24 Hrs Birthplace (State or Foreign Country) 8. 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days BANGI 1 M 2 □ F 0 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 28a-f show 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Medical Exprimer must be restlined at 1 ☐ Yes 2 ☐ No Director 10g. Citizen of What Country? 10e. Street and Number BANGLADESH Funeral 2 should be filed within 72 hours after death n and Mental Hygiene. is marked other than "natural", or items 23 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 □Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: ASIAN Specify: <u></u> 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) OFFICER URVEY 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RAMUZA NURUZZAMAN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Department of Health as Important; If Item 27 is any injury or other trau once. 4627 QUARTER MAASUMANOWAR SON 20c. Location - City or Town, State 20a. Method of Disposition Pages 1 rematory or other place)

LA

3/26/11 ComILLA, BANGLADESH

22. Name and Address of Facility ADEN MUSLIM FUNERAL JER. 1X Burial 2 Cremation 3 Removal from State OMILLA 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses STREET WOODBRIDGE VA-22191 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician; The law requires that the death certificate be executed attending physician and for use as the burial-trans Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 5 ☐ Other (specify) the ☐Yes 2☐No 9 Unknown been signed by should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part II. Division of Vital Records, Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 □Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1∐Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 No Medical Certification: To within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide determined 4 Homicide 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of completed ause of death (Item 23a) (Type, Print) Date filed (Month, Day, Y errimoc State

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 3. Time of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 2011 Marc 12 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year) 5. Social Security Number Age (In vrs. last birthday, 6. Sex **Funeral** 1 🗆 M 2 🖳 8/14/1935 218-30-8406 75 Director Usual Residence of Decedent should be filed within 72 hours after death with the Maryland no Mental Hygiene. marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 Yes 2 No Carroll Hampstead Director MD 10f. Zip-Code 10g. Citizen of What Country? 10e. Street and Number USA 21074 3000 Shiloh Road Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give 11. Marital Status the Medical Examiner 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify white 3 3 Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Carroll Co. Hospital Supply Dept. <u>Supervisor</u> 10 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other. 17. Father's Name (First, Middle, Last) Be Eva Bell Baer Charles C. Wolfe 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 2826 Shiloh Road, Hampstead, MD 21074 Robin Warfel, niece 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hampstead Cemetery 3/17/2011 Hampstead, MD 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Eline Funeral Home M00741 Main Street, Hampstead, MD 21074 benemer 934 S. O pauda 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final weeks **Physician** disease or condition resulting in death) /Medical **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Cause (Disease or injury that initiated events burial-transit requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760 attending physician Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 2 Fetal death Live birth 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) detached 9 Unknown the P.0 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ Division of Vital Records, 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy After this certificate has performed? 2 No 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one director, Be examiner? Other: 2 No Hospital: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA 1 Inpatient 1 🗌 Yes Certification: To 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? funeral 27. Manner of Death 28b. Time of Injury 5 Pending investigation 1 Natural М 1 ☐ Yes 2 ☐ No 2 Accident death. the 1 I or Attend after death Director: A 6 Could not be determined 3 Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by 4 Homicide City or Town, State) Hospital 24 hours a Funeral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) completely and manner stated To the within 2 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 WIL 2 ess of person who completed cause of death (Item 23a) (Type, Print) 30. Name and ade avid 600 North Wolfe St, Baltimore, MD, 21287 eller 31. Date filed (Month, Day, Year)

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Jank.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month March 17. 2011 Sam J. Roveri 2:55a M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death Montgomery Casey House Rockville 5. Social Security Number 7. Age (In yrs. last birthday, r 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 Ohice Funeral 8. Date of Birth March 14 1 X M 2 🗆 F Months Hours **Director** 297-16-0140 Ohio 86 Usual Residence of Deceden or 28a-f show . Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Hant: If item 27, is marked of other than "natural", or items 23a or 28a-f show iny or other traumatic event, the Medical Examiner must be notified at jury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits by Funeral Director 1 Tes 2 X No Maryland Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 2339 London Bridge Road 20906 U.S.A. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 V Yes 2 No 1942—
If Yes, Give Year or Dates. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2 X No Specify: Specify. 3 X Widowed 4 Divorced Completed Caucasian 15. Decedent's Education (Specify only highest grade completed, 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Construction Supervisor Construction Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ (unascertainable) (unascertainable) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) George Hinkle - Brother-in-Law 2339 London Bridge Road, Silver Spring, MD 20906 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Crematory 03/23/2011 Brentwood, Maryland 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 21. Signature of Funeral Service Licensee 11800 New Hampshire Ave., Silver Spring, MD20904 , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, st only one cause on each line. 23a. Part 1. Enter the dis-shock, or heart failu Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Hepatocellular Carcinoma disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or linjury that initiated events signed by the attending physician and be detached for use as the burial-trust Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ş Division of Vital Records, 1 Yes 2 No 3 Probably 4 X Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed? Yes 2 X No To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: $_4$ \square Nursing Home 5 \square Residence 6 \boxtimes Other (Specify) Hospice 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Investigation
6 Could not be Accident Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29c. License number 29d. Date signed (Month, Day, Year) 6 R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller, CRNP 6001 Muncaster Mill Road, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) State MAR 21 2011 Registrar

State Registrar Haviohnuta

MAR 21 2011

DHMH 17 Rev 1/2001

Street

WESTHINSTER, MD 21157

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 2011 Leonard Bernard Richardson 1:13P M March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges Comm Hospital Cheverly P.G. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday, **Funeral** 8. Date of Birth Days 1 XM 2 🗆 F **Director** 579-84-5918 52 Wash. Usual Residence of Decedent 28a-f shov 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Hyattsville MD. P.G. 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 4802 Cooper Lane 20784 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working filed within 72 tal Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Truck Driver Private 12th Be traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filed and Mental H ris marked of ည Leonard B. Richardson, Sr. Dorothy Marie Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s of Health item 27 Sharon Richardson/Wife 4802 Cooper Lane, Hyattsville, Md. 20784 or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot Burial 2 Cremation 3 Removal from State Cemetery 3/23/11 Washington, DC 4 ☐ Donation 5 ☐ Other (Specify) Glenwood 21. Signatule of Funeral Service License 22. Name and Address of Facility
Hackett's Funeral Chapel, Inc.
814- Upshur Street, NW DC 20011 art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions. Examine france (Disease or injury that the death certificate be executed that initiated events resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month signed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, has been signed to the second 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page this certificate 1 Yes 2 No 2**X** No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certification of the funeral director, and the funeral director, is completed filled in by the funeral director, is 25. Was case referred to medical of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Yes 2 X No 1 X Inpatient 2 ER/Outpatient 3 DOA 27. Man fer of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural
Accident (Month, Day, Year) 5 Pending Division 1 Tes Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed Month, Day, Year 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) James Catenvenis, M.D. 3001 Hospital Dr. Cheverly, Md. 20785 31. Date filed (Month, Day, Year) 37. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ MARCH 2011 Ranka Janis Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** P.G. Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) Social Security Number Age (In vrs. last birthday **Funeral** Min May 24, Year 924 Months Hours Latvia 86 228-40-2454 Director Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland 10a. State Director Riverdale P.G. 1 ☐ Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 20737 6811 Riverdale Road, #104 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces?

1 Yes 2 XNo Black, White, etc 1 Never Married 2 Married þ Maryland 21215-0036 hours after 1 Yes 2 No Specify. Specify: White If Yes, Give Completed 3 K Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) within 72 al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Construction Carpenter None Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F is marked o Unknown 0 Unknown Ranka permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 400 Hurley Avenue, Rockville, Inara Apinis/Administrator Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 Burial 2 ACremation 3 Removal from State March Metropolitan Crematory 4 Donation 5 Other (Specify) Alexandria, VA 2011 Francis J. Collins Funeral Home Inc. 500 University Blvd. W, Silver Spring, MD 20901 21. Signature of Funeral Service Licensee JANIS 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ Cholangiocarcinoma Medical resulting in death) Due to (or as a consequence of) **Examiner** Gastric Outlet Obstruction Sequentially list conditions Examine Due to (or as a consequence of) if any, leading to immedia cause. Enter Underlying Hepatorenal Syndrome the Hospital or Attending Physician: The law requires that the death certificate be executed in 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and phete filled in by the funeral director, page 2 should be detached for use as the burial-tanging the philal-tanging the page of the control of the page of the control of the page of t Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖾 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 🗌 Yes 2 🔀 No 1¾☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 🖺 Natural 5 Pending 1 Tes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗠 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 □ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) March 18, 2011 D58182 30. Name and address of person who completed cause of death (Item 23a) (Type, Prin 7500 Hanover Parkway, #101-A, Greenbelt. MD 20770 MD Cecil D. George,

Registrar

31. Date filed (Month, Day, Year)

MAR 21

RANKA

37. Registrar's Signat

Dorothy S. Ruckman

			. For	State of N									106	83
	_	1	State Registrar			Cer	tificate of	Death			Reg. No.			
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Medical Examiner 4a. Facility Name (if not institution, give street and not institution)						kman	4b. City, Town,	or Location	of Death	March		2011 unty of Death	1217	P
	Examin	er	419 Big Elk Chape				E1kto					ecil		
	Funeral		5. Social Security Number 6. Se	х 7. A		ast birthday)	If Under 1 Yea Months Days		24 Hrs. Min.	8. Date of Birt FEB 23	h /, Year	9. Birth	nplace (State on ntry) nsy1var	Foreign
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Baltimore,	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injuy or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition 1 X Burial 2 □ Cremation 3 □		20b. P	Place of Dispo emetery, cred erry H	sition (Name of natory or other pi t Cemete	ace)	Marc	n 26,		ion - City or T		_
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	To the Hospital or Attending Physician: The law within 24 bours after death. To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier Certifying Physical Exam	ner: On the basis of	examination	n and/or inves	tigation, in my opi	nion, death o	occurred at	the time, date a	and place, and	d due to the c	ause(s) and ma	ınner stated.
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10684 State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ Day 2011 Louise Margaret Swim 15, 3:03 a M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Washington Adventist Hospital Takoma Park Montgomery 5. Social Security Number Birthplace (State or Foreign Country)
 IL **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Days 1 🗆 M 2 🕱 F Months Hours Augonth, 23, Year 940 70Yrs. Director 579-52-9724 Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD P.G. 1 Tes 2 R No Hyattsville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 9250 Edwards Way, Apt. 205 20783 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 K No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes Give Specify: White 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Marriott Human Resources Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ige 1 and 2 should be file int of Health and Mental E: If item 27 is marked ၉ Ralph Brogdon Mary Louise Ottes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles W. Swim/Son 1016 Crawford Drive, Rockville, MD 20851 20a. Method of Disposition permit. Page 1 a Department of H Important: If ite 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery crematory or other place)
ce of Heaven
Cemetery 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Gate March 18, 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Francis J. Collins Funeral Home Inc.
500 University Blvd. W., Silver Spri Techard & Hates MD 20901 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trathat initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical use as IF FEMALE yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No
9 ☐ Unknown 5 Other (specify) Month Day Year Pregnant at time of death the signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? 2 🗌 No 2 🖾 N Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2X No ည 1 A Inpatient 2 ER/Outpatient 3 DOA this To the Hospital or Attending Phymitin 24 hours after death.

To the Funeral Director: After the Completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1XX Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Division Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) Medical 1 💆 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) auch 30. Name and address of person who completed cause of death (Item 23a) (Type; Print) Alida Mercedes Andriollo-Espinoza, MD 2101 Medical Park Drive, Silver Spring, MD 31. Date filed (Month, Day, Year) **NAR 17** 2011 2. Registrar's Signature State Registrar

Box 68760

P.O.

Records,

of Vital

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			For State	State of Mar		artment of I rtificate of I			2011	10685	
		,	Registra MFND#24aperMD 1. Decedent's Name (First, Middle, Las		no ou	timouto or i	Journ	2. Date of Dea		3. Time of Death	
	Physician/ Medical Mary Spratt							March	Day Year 11 2011	0710 M	
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	s filed within 72 hours after death with the Maryland tal Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	Funeral	4915 Illinois	Ave. NW	-:-110	200		if . Von ex No	USA		
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Ma	2 sho Ith and 27 is 1		19a. Informant's Name/Relationship (7) Mary J. Mosley	me/Relationship (Type, Print) Mosley/Daughter 19b. Mailing Address (Street and Number or Rural Route Number 4915 Illinois Ave. NW Wa							
re,	ge 1 and 2 s nt of Health i: If item 27 or other tra		20a. Method of Disposition		20b. Place of Dispo		· ·	Date	20c. Location - City of		
imo	Page 1 ment of I tant: If it		1 Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)		Ft. Lin	coln	3/1	9/11	Bladensbı	ırg,MD	
Baltimore,	Department of Important: If any injury or once.		21. Signature of Funeral Service Licens	cc27	7.0	Name and Addre	ss of Facility La	tney's	Funeral	Home, Inc.	
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27	nysician/		Immediate Cause (Final	ne cause on each line.	1 015			^		Interval Between Onset and Death	
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30X	eath c atter d for u	icia	in the past 12 months?	1 Live Birth 2 4 Pregnant at tin		Ectopic pregnand Other (specify)	су		23d. Date of d Month	Day Year	
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Division of Vital Records, P.O.	es tha signed I be de	by	Part II. Other significant conditions co			nderlying cause gi	ven in Part I.		bacco use contribute to the cause of death? Yes 2 No 3 Probably 4 Unknown		
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Ξ	Physic this ce al dire	유	1 Yes 2 No		2 ER/Outpatier		4 L Nursing H		ence 6 Other (Spe	cify)	
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	To the Hospital or Attending Physician: The law requires that the death certificate within 24 burns after death. within 24 burns after death. Completed filled in by the funeral director, page 2 should be detached for use as the	Medical	(Check 2 L. Medical Exami	sician: To the best of my ner: On the basis of exam se Practioner: To the bes	nination and/or invest	igation, in my opinic	on, death occurred a	at the time, date ar	nd place, and due to the	cause(s) and manner stated.	
	To the within To the Comp	2	29b. Signature and title of certifier		it of my knowledge, c	29c. License			29d. Date signed (Mon		
	6		> mane Ra	ne MD		206	8178		MARCH, 11,	2011	
			30. Name and address of person who c Santosh Rang	completed cause of death	(Item 23a) (Type, P	rint)	1 - X -	0- 1	ille, mD	20860	
	Stat	e.	31. Date filed (Month, Day, Year)	37. Registrar's	Signature Z	meal C	Hr Dr	ROCK	ine, mus	20350	
	Registra		MAR 17 201	1 Bruce	B. 1900						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
amend #23a Per Phy G914, 4/18/2011 JH
State of Maryland / Department of Health and Mental Hygien 0 1 1 1686

		1	State Registrar		Ce	rtificate of D	Death		Reg. No	o.		
			1. Decedent's Name (First, Middle, Las	st)			2. Date of D		3. Time of Death			
	Physicia Medic		Egan Greer Skinne			March	16,	2011 Year	4:30 A M			
	Examin		4a. Facility Name (if not institution, give	street and number)	4b. City, Town, or	Location of D	eath	40	. County of Death			
			14808 Soft Wind D	rive		North Po			M	ontgomery	У	
	Funeral		5. Social Security Number 6. S	ex X M 2 □ F 69	s. last birthday)	If Under 1 Year Months Days		Hrs. 8. Date of Bi	irth a <i>y, Year)</i>	g. Birth	place (State or Foreign htry) Lta, GA	
	Director		249-68-5345 1 Usual Residence of Decedent		Yrs.			Sept 1	2, 1	941 Atlar	ita, GA	
	nd thow	ا ۾	10a. State 10b. County	10c.	City, Town or Lo	ocation				1	10d. Inside City Limits	
	aryla sa-f s ified	ect	Maryland Montgome	ery	North P	otomac					1 ☐ Yes 2 🔀 No	
	or 28 e not	ä	10e. Street and Number			10f. Zip Code			10g. C	itizen of What Cour	ntry?	
	1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. If health and Mental Hygiene. If marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at	Funeral Director	14808 Soft Wind D	rive		20878			Un	ited Stat	tes	
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Maryland	hould and N s ma uma	1	19a. Informant's Name/Relationship (7		19b. Maili	ing Address (Street a	and Number o	r Rural Route Numb	er, City o	r Town, State, Zip (Code)	
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Baltimore,	permit. Page 1 a Department of H Important: If ite any injury or of once.		21. Signature of Funeral Seprice Licens	see MO110	2 2	2. Name and Addres	s of Facility	Simple T	ribu	te		
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P.O. Box	requires that the death cert been signed by the attendin should be detached for use	Completed by Physician	1 Yes 2 No	4 ☐ Pregnant at time 9 ☐ Unknown	of death 5 l	Other (specify)				Month	Day Year	
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	To the Hospital or Attending Physician. The law requires that the within U2 Hours after death. To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be detached.	Medical	(Check 2 Medical Exam	sician: To the best of my kr iner: On the basis of examination	ation and/or inves	stigation, in my opinio	on, death occur	red at the time, date	and plac	e, and due to the ca	ause(s) and manner stated.	
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	,		30. Name and address of person who		Item 23a) (Type.					16-70	J11	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Mildred Lorraine Shank Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Meritus Medical Center Hagerstown g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Day, Year) 1 . 1932 1 🗆 M 2 🔀 F Days Mary Land 220-28-7868 Feb **Director** 79 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a. State 10b. Count the Medical Examiner must be notified at Director 1 🖔 Yes 2 □ No Boonsboro Maryland Washington Of. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral items 23a U.S.A. 21713 7 Young Avenue death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S 11 Marital Status Armed Forces Black, White, etc. ò þ 1 Never Married 2 Married ☐ Yes 2 🔀 No Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: Specify: White Yes. Give "natural", 3 X Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Presser Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) should be filed and Mental H Oneida Campbell Clyde Clark 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau 19633 Cool Hollow Road Hagerstown, MD Cindy L. Smith / Daughter Baltimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Locust Grove, Maryland 4 Donation 5 Other (Specify) Zion Cemetery 03/23/2011 21. Signature of Funeral Service Lice is 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 21713 Part . Enter the disease, or complications shock, or heart failure. List only one cluse ons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest interval Between Onset and Death Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of Exami burial-transit Cause (Disease or linjury that initiated events and resulting in death) Last attending physician To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.
To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the home Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death ☐ Ectopic pregnancy
☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown 3 Month Day Pregnant at time of death Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 2 No 3 Probably 4 Unknown 1 Tyes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗌 No 1 🗌 Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 XNo npatient 2 ER/Outpatient 3 DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) Natural 5 Pending 1 Yes 2 No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 🗌 only one 29b. Signature and title of certifier 29d Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2011 Physician/ Month 1:15 Winifred Alexander Summers March Α Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Nursing Center Walkersville 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Maryland **Funeral** Social Security Number Year If Under 24 Hrs 8. Date of Birth 1 □ M 2**X** F (Month, Pay, Days Hours 85 Director 220-18-0917 Dec. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any joury or other traumatic event, the Medical Examiner must be accessed. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No MD Frederick Walkersville 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral <u>56 West Frederick</u> 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 XWidowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Guy F. Alexander M. Orpha Shoemaker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) David A. Summers / 8907 B Pete Wiles Rd., Middletown, MD 21769 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/23/2011 | Middletown, MD Zion Lutheran Cemetery 21. Signature of Funeral Solvice Licenses 22. Name and Address of Facility Donald B. Thompson Funeral Home Main St., Middletown, MD 21769 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final enysician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of) To the Hospital or Attending Physician; The law requires that the death certificate be executed signed by the attending physician and defeached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 5 Other (specify) Month Year Pregnant at time of death Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 ☐ Probably 4 ☐ Unknown 1 Yes Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an within 24 hours after death.

To the Funeral Director, After this certificate has I autopsy performed 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မြ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) . Manner of Death Certificate: 28b. Time of 28c. Injury at 5 Pending Natural work? 2 🗌 No 2 Accident
3 Suicide
4 Homicide Accident Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signat and tit completed cause of death (Item 23a) (Type, Print) ess of person w 516-7 Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

MAR 18

Division or Vital Records, P.O. Box 68760,

within 2

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completely

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

APR 0 4 2011

KOBIN

DHMH 17 Rev 1/2001

State

Registrar

124 MILLER STREET

back

29c. License number

29d. Date signed (Month, Pay, Year)

GRANTSVILLE, MD 21536

11

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registra Certificate of Death 0690 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Month Ada Genevieve Smith 5:00p Medical 2011 March 13 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Golden Crest Assisted Living Hampstead Carroll Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) (Month, Day, 1 □ M 2 屎 F Days Min. Year Director 230-03-7106 27 1913 Sept Usual Residence of Decedent 28a-f show 10c. City, Town or Location er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10d. Inside City Limits Director Maryland Baltimore Parkton 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral United States 21120 2727 Mount Carmel Road 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 X No Black, White, etc. 1 X Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: white 3 ☐ Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) auto dealership bookkeeper Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F is marked o မ Roswell T. Smith Bettie Godwin permit. Page 1 and 2 should by Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2727 Mount Carmel Road Parkton, Maryland 21120 Lucrecia Hinton / niece Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Page 1 1 X Burial 2 Cremation 3 X Removal from State 4 Donation 5 Other (Specify) Downing's Cemetery Oak Hall, Virginia 2011 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eline Funeral Home M01072 urv 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approx Approximate Interval Between shock, or heart failure. List only one cause on e. ch line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) 0 4ns Medical Due to (or as a consequence of) **Examiner** Eequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) burial-1 physician s the burial Physician/Medical Box 68760 ending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ atter for t in the past 12 months?
1 Yes 2 No Pregnant at time of death Month signed by the a 1 ☐ Yes ∠ g ☐ Unknown 9 🗌 Unknown P.O. | Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 1 ☐ Yes 2 💆 No 3 ☐ Probably 4 ☐ Unknown peen 24b. Were autopsy findings available prior to completion of cause of 24a. Was an Jas page 2 autopsy perform Hospital or Attending Physician: The certificate 2 N 1 🗌 Yes ☐ Yes director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 **Ž**No ည 1 Yes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Cher (Sp funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After Natural Accident Suicide 5 Pending injury or . s after de. ral Director: Ar 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) filled in Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier within 2. Certifying Nurse Practioner- To the best of my knowledge, diat the time, date and place, and due to the cause(s) and manner 29b. Signature and title of certifier nth, Day, Year) 29d. Date signed (M. 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) John Middleton MD 688 C Poole Rd Westminster, MD 21157 31. Date filed (Month, Day, Year) Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 18, 2011 Year 1:15 p M Aleta Mae Scanlon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Carroll Hospice Dove House Westminster Carroll 5. Social Security Number 8. Date of Birth 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2**X** F April Day Year 1934 Months Hours 302-28-9035 76 Director Usual Residence of Decedent or 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Carroll Westminster 10f. Zip Code 10g. Citizen of What Country? Funeral within 72 hours after death with 989 Sling-Ora Ct. 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒No 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: If Yes, Give Completed 3₺ Widowed 4 □ Divorced White Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker own home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jesse T. McHenry Molly Schaible 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other tra Marsha Anderson/Daughter 989 Sling-Ora Ct. Westminster, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Grandview Cemetery 3/22/2011 Salem, Ohio of Funeral Service Li 22. Name and Address of Facili Pritts Funeral Home & Chapel, PA 412 Washington Rd. Westminster, MD 21157 23a. Part 7. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions Examine Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Cther (specify) in the past 12 months? Day Pregnant at time of death 1 Yes 2 No 9 Unknown P.O. I Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Kyes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 ☐ Yes 2 ☐ No Yes 2 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 No 1 Tes 일 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) injury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 Certifying Physician the best of nowledge, occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examin . On the basis 3 Certifying Number Practioner: vestigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated edge, death occurred at the time, date and place, and due to the cause(s) and manner as stated are best of my k 29b. Signature and title of certifie WIL 4 30. Name and address of pa State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month MC1+ Physician/ Year 2011 9:30 PM Alfred John Stricklin, Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore Baltimore Levindale Hebrew Geriatric Hospital Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months Hours 1 🗓 M 2 🗆 F Month Day Year) 26 84 Texas **Director** 454-20-1378 Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ıral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 X No Silver Spring Maryland Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 20903 9820 Braddock Road death \ 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces? 1 Never Married 2 X Married 至 Baltimore, Maryland 21215-0036 within 72 hours after WWII 1 Yes 2 X No Specify: If Yes, Give Year or Dates Specify: "natural", White 3 Widowed 4 Divorced Completed the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Washington Gas Sales Representative Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Nenia Irene Cockrill Alfred John Stricklin, Sr. Page 1 and 2 should be 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19064 McFarlin Dr., Germantown, Maryland 20874 Barry G. Stricklin - Son 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State George Washington Cem 03/23/2011 Adelphi, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Hines-Rinaldi Funeral Home, 21. Signature of Funeral Service License MO#1070 111800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ₽nysician/ ATHENOSCIEROTIC CANDIOVASCULAR disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leaving to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence St. attending physician and for use as the burial-tr-nsit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death the 9 Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed by det 2 Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 autopsy certificate 1 Yes 2 No 1 Yes 2 ANO **Director:** After this certific d in by the funeral director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: work 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide within 24 hours after death

To the Funeral Director: A
completed filled in by the f Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number determined building, etc. (Specify) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29d. Date signed (Month, Day, Year) မ 251 MARCH 20, 2011 Wallan und 1)31136 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BENVEDERE AU. BACTIMONE, MO 21215 CWALLACE Min 2434 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March Physician/ 201T 10:45 Smith Amelia Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Montgomery Arcola Health & Rehab. Center Silver Spring If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Dec. 23, Year) 916 Min. 1 🗆 M 2 🖾 F Months Days Hours D.C. 94 Director 220-28-5235 Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State death with the Maryland notified at **Funeral Director** 1 Yes 2 X No MD Silver Spring Montgomery 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 6 items 23a or ner must be r 9314 Sudbury Road USA 20901 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces?

1 Yes 2 X No Black, White, etc permit. Page 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or any injury or other traumatic event, the Medical Examinone. Ś 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates SpecifWhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry National Education Elementary/Seconday (0-12) College (1-4 or 5+) Association 12 Supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Bessy Legg William Bender 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Haymarket, Dale A. Smith/Son Gore Drive. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State March 18 Metropolitan Crematory Alexandria, VA 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licensee Francis J. Collins Funeral Home Inc. 500 University Blvd. W. Silver Spring,MD 20901 23a. Part 1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final Physician/ Severe Dehydration disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Dysphagia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Hospital or Attending Physician: The law equires that the death certificate be executed and Cause (Disease or iinjury Dementia that initiated events resulting in death) Last Due to (or as a consequence of): burial anding physician use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No o Month Dav Year 5 Other (specify) Pregnant at time of death signed by the a 1 ☐ Yes 2 ₹ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown een si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has the autopsy performed' 1 Yes 2 No 1 Yes 2 No After this certificate funeral director, pag Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗆 Yes 2 🛣 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation within 24 hours after deatl

To the Funeral Director:
completed filled in by the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year)

State Registrar 31. Date filed (Month, Day, Year)

NAR 2 1 2011

2. Registrar's Signature

30. Name and address of person who completed Yeheyes Negussie MD

20

D45471

cause of death (Item 23a) (Type, Print)
1111 Spring Street, #214, Silver Spring, MD 20910

March 18, 2011

State of Maryland / Department of Health and Mental Hygiener for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month March Physician/ 2011 1850 M Jerome Schore Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery Rockville Shady Grove Adventist Hospital 9. Birthplace (State or Foreign Country) New York 8. Date of Birth (Month, Day, Year) July 30, 1924 Social Security Number If Under 1 Year If Under 24 Hrs. Funeral Months 1 🗶 M 2 🗆 F 86 3 **Director** 133-16-5956 Usual Residence of Decedent 3/19/2011 or 28a-f shov notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 🗓 No Germantown Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō is marked other than "natural", or items 23a o aumatic event, the Medical Examiner must be Funeral 20874 13116 Country Ridge Drive hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married 2 X No Completed by Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Specify: White 3 X Widowed 4 Divorced Year or Dates 16b. Kind of Business Industry 15 Decedent's Education 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. Master Photo Engraver U.S. Government Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be fil.
Department of Health and Mental
Important: If item 27 is marked of any injury or other traumatic ew Sadie Ashkenazy Elias Schore 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 13116 Country Ridge Drive, Germantown, MD 20874 Kevin Schore - Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Garden of Remembrance 03/21/2011 Clarksburg, Maryland 21. Signature of Funeral Service Licen ee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. MD20904 11800 New Hampshire Ave., Silver Spring, 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock or heart fa re. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Examiner Ya Sequentially list conditions. It any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury e attending physician and ed for use as the burial-transit requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death 2 No ed by the a detached f 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed to Completed by 1 Yes 2 No 3 Probably 4 Unknown is certificate has been si director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician; The law autopsy performed 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completed filled in by the funeral to 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c, Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No Investigation Could not be Accident Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Mehaci 2011 064478 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 medical mehour Fischatsian MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 2011 MAR 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death .Day 2011 March 18, Physician/ 6:15 aM Saucedo Julio U. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Silver Spring Holy Cross Hospital If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number 7. Age (In vrs. last birthday **Funeral** (Month, Day Year) ec. 25, 1925 Country Guatemala 1**x** M 2 □ F Hours Dec. Director 85 578-76-3352 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County filed within 72 hours after death with the Maryland Director 1 Yes 2X No Silver Spring Montgomery 10f, Zip Code 10g, Citizen of What Country? 10e. Street and Number Funeral USA 20901 10802 Lombardy Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Was Decedent Ever in U.S. Armed Forces? Black, White, et 1 Never Married 2 X Married þ 1 ⊠Yes 2 □ No Specify: Guatemalan White Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates "natural", 3 Widowed 4 Divorced Completed other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) if Health and Mental Hygiene. item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Footwear Shoemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be Jacoba Saucedo Ednejardo Vides 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 10802 Lombardy Road, Silver Spring, MD 20901 Maria A. Saucedo/Wife 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Gate of Heaven Cemetery Department of Important: If it any injury or o 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State March 2 Silver Spring, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee rancis J. Collins Funeral Home Inc. 500 University Blvd. W., Silver Spring, MD 20901 23a. Part 1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each | Approximate Interval Between Onset and Death the death. Do not enter the mode of dving, such as cardiac or respiratory arrest Immediate Cause (Final Ph, sician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, that initiated events Due to (or as a consequence of) resulting in death) Last cate has been signed by the attending physician a page 2 should be detached for use as the burial-Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Dav 5 Other (specify) Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performed 1 ☐ Yes 2 🗷 No 1 Yes 2 No 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) funeral director, Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 8c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Accident Investigation 24 hours after death Funeral Director: by the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier pleted (Check ithin 2 the F Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of cer 29c. License number 29d. Date signed (Month, Day, Year) D45471 March 18, 2011 Nuse of death (tem 23a) (Type, Print) Glen Road, Silver Spring, MD 20910 30. Name and address of person who complete Yeheyis Negussie, eted

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAR 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) MIRCH 0625 M Physician/ 2011 Randolph C. Selph, Sr. Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Salish ferinsula Regional Medical Cente 8. Date of Birth (Month, Day, Year) 12–26–1942 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. '. Age (In yrs. 68 **Funeral** Virginia Min. 221-26-3037 Hours Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Director 1 Yes 2 No DE Sussex Laurel 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number 19956 Funeral 216 10th Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc þ 1 Never Married 2X Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2X No Specify: Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Auto Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Margaret (Prosser) Selph Carl Selph Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 36371 Susan Beach Road Delmar, De. 19940 Lisa Peterman (Daughter) 20c. Location - City or Town, State 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 ☐ Burial 2X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, Delaware First State Cremation 3-14-2011 700 West Street 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the Bisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Hannigan, Short, Disharoon F.H. Laurel, De. 19956 Interval Between Onset and Death Immediate Cause (Final CHNONIC OBSTRUCTIVE Physician/ PULMONAN DISENSE 16611 disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, it any cool with list conditions, it any cool with the cause. Enter Underlying Examiner Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed aate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Hospita Other: ပု 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 5 Pending 1 Natural 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 A Homicide determined Medical 29a. Certifier Lecritifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier IMP AVI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL St. SALISBURY Md. State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiena Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Mar 24, 2011 Physician 1:14 PM Shaffer Louise Mary /Medical 4c. County of Death 4h. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Golden Living Center Cumberland If Under 1 Year | If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Min 1□ M 2□ 🕏 WV 98 Jun 5, 1912 217-10-7187 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heatth and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at 1 □ ¥es 2 □ No MD Allegany Cumberland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 26 Race Street 21502 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 14. Race - American Indian 11 Marital Status Black, White, etc. 1 Never Married 2 Married 1 □ Yes 2 □**X**o 3altimore, Maryland 21215-0036 Specify. Specify: þ 3 ☐ Widowed 4 ☐ Divorced white Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Food Service Dept. Fort Hill High School 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lille May (McMorrow) James William French James 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Sharon Lichty 28 Race Street Cumberland MD 21502 daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 3/28/2011 Hillcrest Memorial Park Cumberland MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Eacility
Scarpelli Funeral Home, PA 23a. Part 1. Inter the disease for complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition resulting in death)

a. 108 Virginia Avenue: Cumberland, MD 21502 Approximate Interval Between Onset and Death Physician /Medical Examiner Sequentially list conditions, if any, leading to include cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending physician for use as the buria Physician/Medical 23c. if yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy Month Dav Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an autopsy 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical examiner? 26. Place of Death Check onl one Other: 4 Jursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 | Inpatient 2 | ER/Outpatient 3 | DOA P 28a. Date of Injury 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Natural 2 Accident (Month, Day Year) 5 ☐ Pending investigation Injury 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

State Registrar

WONSOCK SHIN MP APR 0 1 2011

29b. Signature and title of certifier

925 Bishor Walsh Rd

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD

00055325

29d. Date signed (Month, Day, Year)

2011

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ March 18. Day 2011 11:25 P M Clarence Lansdale Tippett Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Calvert Prince Frederick Burnett-Calvert Hospice House If Under 1 Year If Under 24 Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours 12-22-1938 Mary land Director 219-38-3184 Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b County 10d. Inside City Limits 10c. City. Town or Location Director 1 ☐ Yes 2 🕅 No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2915 Lower Marlboro Road 20736 United States death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Bace - American Indian rmed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 🕅 Married þ Baltimore, Maryland 21215-0036 hours after 1 Yes 2 X No Specify: If Yes, Give Year or Dates. 1960 Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter. Superintendent Construction marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) should be filk th and Mental H ည Guy Emory Tippett Eveyln Margaret Rawlings other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Maybelle E. Tippett - Wife 2915 Lower Marlboro Road, Owings, Maryland 20736 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☒ Other (Specify) Entonbment 03/22/2011 So. Mem. Gardens Dunkirk, Maryland Rausch Funeral Home, P.A. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility P. O. Box 100, Owings, Maryland 20736 4 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician rostate disease or condition lears Medical Due to (or as a consequence of) Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) Examin that the death certificate be executed burial-tra that initiated events Due to (or as a consequence of) resulting in death) Last ending physician a use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death 9 Unknown 1 Yes 2 L the signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 X No 3 ☐ Probably 4 ☐ Unknown 1 Yes s been sign 24b. Were autopsy findings available prior to completion of cause of 24a. Was an ate has k To the Hospital or Attending Physician; The law within 24 hours after death. autopsy perform death?
1 Yes 2 No this certificate 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: $_4$ \square Nursing Home $_5$ \square Residence $_6$ $\raisebox{-1.5ex}{$\stackrel{\frown}{\hbox}$}$ Other (Specify) $\raisebox{-1.5ex}{$\stackrel{\frown}{\hbox}$}$ Hospice House 2 No within 24 hours and con-ည 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🗷 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 29a. Certifier 1 🔀 Certifying Physîcian: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 0005906 March 21, 2011

State Registrar 32. Registra Signature

Arati C. Patel, MD 110 Hospital Road, Suite 212, Prince Frederick, Maryland 20678

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MAR 2.1

31. Date filed (Month, Day, Year)

11-01/28 Cheryl Dawn The	oma	Please Type or Print in Black In State of Maryland / Dep	ndelible li artment o	nk. Ensur f Health an	e All Copie	s Are Leg	ible	10699
		otato or maryiana / Dopi	rtificate o		iu wentai ii		3. No.	,0000
Physicia	an/	Decedent's Name (First, Middle,Last)				2. Date of Death		3. Time of Death
Medical Exami	ner	Chery1 Dawn Thomas 4a. Facility Name (if not institution, give street and number)		41-07-7		March 3, 20	011	1050 hrs
		106 W. Railroad Street		Ridgely	Location of Death		4c. County of Death Caroline	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs.	last birthday)	If Under 1 Yea		. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	
Director		216-64-9611 1 M 2XF	54 Yrs	Months Day	s Hours Min.	07/06/1	956 Foreig	on untryMaryland
any		Usual Residence of Decedent 10a. State 10b. County 10c. City	, Town or Locat	ion				10d. Inside City Limits
B								1 X Yes 2 No
farylar 283-f s	Director	MD Caroline Rid 10e. Street and Number	gely	10f. Zip Code		10	g. Citizen of What Cou	ntry?
h the N		106 West Railroad Avenue		21660		u	nited Stat	es
death with the Maryland or items 23s or 28s-f show must be notified at once.	unera	11. Marital Status 1 Never Married 2 Married Armed Forces?			spanic Origin? (Sp n, Mexican, Puerto	ecify Yes or No-		can Indian, Black,
ter dea	ш	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1	Yes 2 X No	specify:		Specify: TTL =	_
11215-0036 Id be filed within 72 hours after Aental Hygiene. arriced other than "natural", c event, the Medical Examiner.	d b	15. Decedent's Education (Specify only highest grade completed)	16a. Deceder	nt's Usual Occupa	tion (Give kind of w		16b. Kind of Business/	
16 n 72 h ical fi	ete	Elementary/Secondary (0-12) College (1-4 or 5+)	- auring m	iost or working life	e. DO NOT use retir	rea)		
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215 be file rised o	Be	James Coleman				ne Morri	,	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene. 7 is marked other than "natural", or items 23a or 28a-7 ab natic event, the Medical Examiner must be notified at once	은	19a. Informant's Name/Relationship (Type, Print)	1		et and Number or F	tural Route Numb	er, City or Town, State	
Malth alth		John Elburn - Son 20a. Method of Disposition 20b.		Fitzwate sition (Name of cer			ia, PA 191	
Baltimore, pemit. Pages 1 a Department of He Important: If ite		1 X Burial 2 Cremation 3 Removal from State	crematory or other	her place)	11272			,
nit. Pa artmer fortant	V	4 / Donation 5 Other Specify: We 21. ignature of Funeral Service Licenses	sley Ch	lame and Address	s of Facility		Rock Hall,	
Dep Der Dep	1	revoluca M) Welling	/ Fe	11ows, H O Speer	lelfenbei Road Che	n & Newn stertown	am Funeral	Home. P.A. 21620
Physician /Medical		2 a. Part I. Enter the disease, or complications that caused the deat failure. List only one cause on each line.	Do not enter the	he mode of dying,	such as cardiac or	respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death) a. Mixed drug into Due to (or as a consequence of Due to (o		ion(Tram	adol,Cita	alopram,	Fentany1)	Death
		Sequentially list conditions, b.						
		if any, leading to immediate Due to (or as a consequence of cause. Enter Underlying Cause	of):					
si d	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of	of):					
Box 68760, re death certificate be executed the attending physician and red for use as the burial - transit	g	d. AMENDED 23.27.2	922 f c0	15 5 12	11			
60, ate be ohysicii	an/Med	IF FEMALE: AMENDED 23,27,2		713 J=12-	-11 SM		23d. Date of delivery	
687 certific	ian/	23b. Was decedent pregnant in the past 12 months? 1 Live birth 1 Pregnant at time of de	ath =	tal death 3	Ectopic pregnar	псу	Month E	ay Year
Box death	nysici	1 Yes 2 No 9 Unknown	∍ain 5 Oti	her (Specify)				
that the detache	by Phy	Part II. Other significant conditions contributing to death but not r	esulting in the u	inderlying cause g	given in Part I.		acco use contribute to	
Vital Records, P.O. bytician: The law requires that the this certificate has been signed by a director, page 2 should be detach.						1 Yes	2 No 3 Prob	topsy findings available
COFC law re has be	Completed					autopsy	prior to c	ompletion of cause of
r Re ii The tificate		25. Was case referred to medical		26 Place	of Death (Check o	1 Yes 2	No 1 ✓ Ye	s 2 No
of Vital Records, ig Physician: The law requirement. The transfer this certificate has been a neral director, page 2 should be	ď	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2	ER/Outpatient		Other		esidence 6 🗸 Other	Scene
J Of Jing Ph After t funeral	Ë	27. Manner of Death 28a. Date of Injury (Month, Day, Year)	28b. Time of la			28d. Describe ho	w injury occurred	
Sior Attend r death ector: by the	Cati	2 Accident Investigation Ed 3-3-11	fd 10:4	o an	res 2 X No	Unknown	The state of the s	18
Division pital or Attent cours after death cour after death filled in by the	Certification:	Suicide Sui		st, ractory, onice b			eet and Number or Ru te) 106 W. Ra	ilroad St.
Hos Fun Fun		29a. Certifier 1 Certifying Physician: To the best of my knowled			ate and place, and	due to the cause(s) and manner as state	
To the Hos within 24 h To the Fun	Medical	one) 2 Medical Examiner: On the basis of examination a and manner stated.	ind/or investigat					
93	2	29b. Signature and title of certifier		29c. License O.C.!			29d. Date signed <i>(Mor</i> March 4 , 2011	nth, Day, Year)
	-	30. Name and address of parts on who completed cause of death (Item	1 23a)					
R m		Pamela E. Southall, MD Assistant Medical Exa	•	W. Baltimore	e Street, Baltin	nore, MD 212	223	
Sta Regist	ate rar	31. Date filed (Month, Day, Year) AR 9 2011 32. Registrar's Signatu	1. do	M				
Mograti	النه		7					

11-01727 Anthony Phillip 7	Γhor		pe or Print i state of Maryla							egib	le.		700
		1- For State Registrar		Cei	rtificate of	Death	_			Reg. No	0.		
Physicia Medical Exami		1. Decedent's Name (First, Mide Anthony Philip	Thomas						2. Date of D Month March 3	Day , 2011		1050	
		4a. Facility Name (if not instituti 106 W. Railroad Stre		umber)		4b. City, Tow Ridgely	m, or Lo	cation of Deat	h		4c. County of Caroline	Death	
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs. I	ast birthday)	If Under 1		If Under 24Hr	_	Birth (MI	M/DD/YYYY)	9. Birthplace (S Foreign	tate or
Director	Months Days Hours Min.								lvania				
d how any		10a. State 10b. County	roline	10c. City,	Town or Locat	on					_		de City Limits es 2 No
farylan 28 2-f s Lat one	Director	10e. Street and Number	поттие	KLUE	sery	10f. Zip Co	ode			10g. C	itizen of Wha	at Country?	
h the h	흐	106 West Railr				2166						States	
ath wit irems 2	uneral	11. Marital Status 1 Never Married 2 X	Married Armed F					nic Origin? (S Mexican, Puert		No-	14. Race - White,	- American Indiar etc.	i, Black,
fter de 17, or i	ш		ivorced If Yes, Give Ye or Dates:	2 X No ar	1	Yes 2X	No :	specify:			Specify:	White	
hours a natura Examir	ed by	15. Decedent's Education (Special Control of the Co	ecify only highest gra		16a. Deceden during m			n (Give kind of O NOT use re		16b.	Kind of Bus	iness/Industry	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	Contra	actor					Constr	uction	
215-0036 be filed within 7 trat Hygiene. *ked other than		17. Father's Name (First, Middle	e, Last)				18	.Mother's Nam	e (First, Middle	e, Maide	n Surname)		
2121 uld be f Mental marke c event	To Be	Philip Newell 19a. Informant's Name/Relation			19b. Mailing	Address (NNA RAI and Number or				, State, Zip Code	1)
MD d 2 shoutth and is a 27 is numation		Philip N. Thou	nas – Fath					eck Roa					
MOFE, Pages I and tent of Heal unt: If item		20a. Method of Disposition 1 Burial 2 X Cremation	on 3 Removal f		Place of Dispos crematory or oth		of ceme	tery,	Date	200	. Location - 0	City or Town, Sta	te
time r. Page tment or		4 Donation 5 Other S	Specify:		esapeak	e Crem	_		09/201	1 S	teven	sville,	MD
Balti permit. Departm Importa		21. Signature of Funeral Service	M \	Minel	/ Fe	110ws	He	lfenbei oad Che	n & Ne	wnaii	Fune:	ral Home	P.A.
Physician		23a. Part I. Enter the disease, o failure. List only one cause		caused the death.	. Do not enter the	ne mode of d	lying, su	ich as cardiac	or respiratory	arrest, si	nock, or hear	rt Approx	imate Interval en Onset and
, IMedical Examiner		Immediate Cause (Final disease or condition resulting in death)	e a. Fenta			n						_	Death
> /		Sequentially list conditions,	b	a consequence o	я).								
	iner	if any, leading to immediate cause. Enter Underlying Cause		a consequence o	f):								
d sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence o	f):								
execute in and il - tran	_	X UNPENDED	dAMENDED	23a,27,	28a-f p	er me	g91	4 4-7-	ll vt			+	
60, ate be o	Medi	IF FEMALE:	23c. If yes,	outcome of preg						2	3d. Date of d	delivery	
Box 68760, e death certificate be the attending physic ed for use as the bur	Physician/Medica	23b. Was decedent pregnant in t past 12 months?	I I Cive	birth nant et time of de	ath -	tal death	_	Ectopic pregn	ancy		Month	Day	Year
Box: death the attered for u	ysic	1 Yes 2 No 9 Ur			5 Oti	ner (Specify,	<i>'</i> —						
Division of Vital Records, P.O. Box 68760, To the Hopital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	þ	Part II. Other significant condi	itions contributing t	o death but not re	esulting in the u	nderlying ca	use give	en in Part I.			_	oute to the cause Probably 4	_
rds, require been si hould b	leted								24a. Wa	as an		ere autopsy findi	
Division of Vital Records, at all or Attending Physician: The law requirers after death. After this certificate has been silled in by the funeral director, page 2 should be	Completed									formed?	de	eath?	2 No
tal R	Bec	25. Was case referred to medic examiner?	Il leavitely -		1	-15		Death (Check		_		1	
of Vir Physic ter this eral dir	은	1 Yes 2 No 27. Manner of Death	28a. Date		ER/Outpatient 28b. Time of I			ther ₄ Nursi	ng Home 5 28d. Describ				_
on of ending Ph. ath. or: After ti	tion		ndino	h, Day,Year) 5-3-11	fd 10:	45am 1	Yes	5 2 🗶 No	unkno	WD			
Division To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 X Cou	uld not be 28e. Plac	ce of Injury - At he	ome, farm, stree		fice buil	ding, etc.	28f. Location or Town	(Street , State)	and Number	or Rural Route	Number, City
ospital nours neral ly filled		29a. Certifier	ermined (Specify,	10010		red at the tim	ne date	and place, an	Ridge	ly.	Md.		
the H thin 24 or the F mplete	Medical	(Check only	aminer: On the basis and manner:	of examination a									i
	Me	29b. Signature and title of certification	Fier				icense r			0.6		d (Month, Day, Y	ear)
3		Punch for	uthall, N				D.C.M.	.E.		Ma	arch 4, 20	11	
Rm		30. Name and address of perso Pamela E. Southall, I	•	ise of death (Item Medica! Exa		W. Baltir	more s	Street, Balt	imore, MD	21223	3		
S	ate	31. Date filed (Marth, Pay, Year		egistrar's Signatu		MI							
Regis	trar	MMM O	COUNTY DE	moune 1	C. APRIL	No. of Contract of							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 2:35 2011 TODD, March 18 **GEORGE** WEBSTER Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Worcester Berlin Nursing Home If Under 1 Year If Under 24 Hrs. Social Security Number Age (In yrs. last birthday, 8. Date of Birth Birthplace (State or Foreign Country) Funeral Days Hours 1 ☑ M 2 🗆 F Months (Month, Day, Year) 03/11/1945 Director 219-42-8813 Maryland 66 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Director Maryland Crisfield Somerset 1 XYes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1A Potomac Street 21817 U.S.A. death v Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 XYes 2 No 1963-Black, White, etc. "natural", or 1 Never Married 2 Married þ George Todd Baltimore, Maryland 21215-0036 hours after 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced 1967 Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any Injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Waterman Seafood Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) George W. Todd, Jr. Sarah Janet Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Elaine Todd (Wife) 1A Potomac Street - Crisfield, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1
Burial 2
Cremation 3
Removal from State 4 Donation 5 Other (Specify) rematory of Delmarva 03/19/2011 Delmar, DE 21. Signatur of Poral Services Eradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, Bradshaw .Tr Approximate Interval Between Onsel and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician. Aspiration days disease or condition resulting in death) Medical Due to (r as a consequence of) **Examiner** End Stage Sequentially list conditions, cause (Disease or iinjury that initiated events or Attending Physician; The law requires that the death certificate be executed tensior sician and burial-trans Due to (or as a consequence of) resulting in death) Last attending physician I for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Dav Month Year Pregnant at time of death signed by the a d be detached for 1 Yes 2 0 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ▼ Unknown been si should b Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an page 2 s autopsy performed? death? 1 ☐ Yes 2 ☐ No this certificate 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 XNursing Home 5 Residence 6 Other (Specify) Hospital: 2**X** No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours fler death.

To the Funeral Director After thi
completed filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 🗌 Yes 28b. Time of 28d. Describe how injury occurred Certificate: 5 Pending iniury 1 XNatural 2 Accident
3 Suicide
4 Homicide 2 🗀 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) To the Hospital ledical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 29c. License number March 18, 2011 н 0070020 30. Name and address of person who complete (Laus of death (Item 23a) (Type, Print)

Registrar

DHMH 17 Rev 7/2009

State

D.O.

32. Resistrar's Signature

Diane Ceruzzi
31. Date filed (Month, Day, Year)

MAR 22

9715 Heathway Dr, Berlin, MD 21811

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day Taylor Αм Mae 2011 4:19 3 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Wicomico Salisbury 30880 Johnson Road If Under 1 Year | If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) 1 □ M 2 🗓 F Georgia Director 228-42-7072 78 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🌠 No Salisbury MD Wicomico 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Completed by Funeral USA 21804 30880 Johnson Road . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ី No Specify: White 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Shirt Factory Seamstress 8 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Lankford Maggie Lena Pearson Lorenzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7636 Parsonsburg Road, Parsonsburg, MD 21849 <u> Terrie R. Woodgeard - Daughter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State Springhill Memory Gd. 3-19-2011 Hebron, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Bounds Funeral Home E. Main Street, Salisbury, Maryland 21804 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each it.e. Immediate Cause (Final ancer Physician/ month disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and use as the bunial-tran that initiated events Due to (or as a consequence of) resulting in death) Last s been signed by the attending physician should be detached for use as the buinal Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 4 Pregnant Month 5 Other (specify) Pregnant at time of death 9 | Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s autonsy perform After this certificate 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical examiner? **Division of Vital** funeral director, 26. Place of Death (Check only one) Be Other: 4 Nursing Home Hospital: 1 Yes 2**X** No ဂ္ 1 Inpatient 2 ER/Outpatient 3 IDOA 5 Residence 6 Other (Specify) 28b. Time of 27. Mannér of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred ☑ Natural 5 Pending injury work? 2 🗌 No Accident Investigation 24 hours after death Funeral Director: filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed (Check within 2 To the only one 29b. Signature and title of certific 29d. Date signed (Month, Day, Year) 29c. License number WY D54127 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alon mo 21804 100 Dower 31. Date filed (Month, Day) 32. Registrar's Signature State 6 2011 Registrar

11-01987		Please Type or Print in Black Indelible Ink. Ensure All Copie		egible.	
Donald Lee Usilto		Jr. State of Maryland / Department of Health and Mental Historia State Certificate of Death	ygiene	201 Reg. No.	11 10703
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of D		3. Time of Death
Medical Examir		Donald Lee Usilton, Jr.	March 1	3, 2011	0913 nrs
.		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 101 Morgnec Road Apt B304 Chestertown		4c. County of Kent	Death
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min		Birth (MM/DD/YYYY)	Birthplace (State or Foreign
Director		212-72-0493 1X M 2 F 52 Yrs.		5/1958	Maryland
ku a	ŀ	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
d how a					1 XYes 2 No
aryian	Director	MD Kent Chestertown 10e. Street and Number 10f. Zip Code		10g. Citizen of Wha	at Country?
the M a or 2	[급	101 Morgnec Rd. Apt # 304B 21620		United St	ates
with ms 23	E a	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp			American Indian, Black,
r death	Funeral	1 X Yes 2 No	Rican, etc.)		
s after	<u>۾</u>	3 Widowed 4 Divorced If Yes, Give Year 1976–1982 1 Yes 2 No specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of v	work dono	Specify: To 16b. Kind of Busi	
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)		TOD. KING OF BUS	iness/industry
D36 Ithin 7 ne.	힑	12 Painter		Home In	mprovement
5-0.		17. Father's Name (First, Middle, Last) 18.Mother's Name	(First, Middle	e, Maiden Surname)	
121 d be fi lental iarked event,	8	Donald Lee Usilton, Sr. Sharon A 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or F			
D 2 shoul and M	욘	The state of the s			
and 2 and 2 lealth item 2	ŀ	Mary Usilton / Wife 101 Morgnec Road Chest 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery,	Date		City or Town, State
Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		1 Burial 2 K Cremation 3 Removal from State crematory or other place)	116 (20)	11 0	
altin nit. P sartne sortan	ł	4 Donation 5 Other Specify: Chesapeake Cremation 03/			
M F F F F		Fellows, Helfenbein 130 Speer Road Ches 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of	n & New sterto	wnam Funei wn, maryla	ral Home, P.A. and 21620
Physician		failure. List only, one cause on each line			Retween Onset and
Examiner	-1	Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):	phine)	intoxicat	ion Death
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	힐	if any, leading to immediate Due to (or as a consequence of):			
	xamine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last use (c. Due to (or as a consequence of):			
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Box 68760, e death certificate but the attending physic ed for use as the but	8	IF FEMALE: 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the		23d. Date of d	
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Boy death the attr	hysici	1 Yes 2 No 9 Unknown 9 Unknown			
of Vital Records, P.O. Box 68760, ing Physician: The law requires that the death certificate be execute After this certificate has been signed by the attending physician and uneral director, page 2 should be detached for use as the burial - tran		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.			oute to the cause of death?
S, P					Probably 4 Unknown
ord aw req as bee	ompleted			opsy pri	rere autopsy findings available for to completion of cause of
Rec The la	틩		1 Yes		eath? ✔ Yes 2 No
Division of Vital Records, rat or Attending Physician: The taw requirers after death. al Director: After this certificate has been sited in by the funeral director, page 2 should be a be and the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director, page 2 should be a second to the funeral director.	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin			
Physi Physi er this	유	1 Ves 2 No rospital 1 Inpatient 2 ER/Outpatient 3 DOA Veriet 4 Nursin 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Residence 6 🗸	
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ivisiol or Attene after death Director:	<u>[</u> g	2 Accident Investigation	Unkno 28f. Location		r or Rural Route Number, City
Divisior Hospital or Attend 24 hours after death. Funeral Director:	Certific	Suicide 6 Could not be determined (Specify) Residence	Cheste	State 101 Mon	r or Rural Route Number, City rgnec Rd. Apt B30
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transil		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 V Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To t with To t	Medical	and manner stated. 29b. Signature and title of certifier 29c. License number			d (Month, Day, Year)
	-		ME	March 14, 2	
4	-	30. Name and address of person who complete dcause of death (Item 23a)			
+	- [Theodore M King .Ir MD Assistant Medical Examiner 111 Penn Street Baltimore	MD 212	01	

State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State
Registraramended item #7/wchd/te/3/18Centificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Medical Vinyard Jr. Henry Lee 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death WILDMILO Coastal Hospice at the Lake Salisbury If Under 1 Year If Under 24 Hrs. 8. Date of Birth 1/19/45 9. Birthplace (State or Foreign (Month, Day, Year) **Funeral** Social Security Number 7. Age (In yrs. last birthday) Hours 1 🛛 M 2 🗆 F Days Min 221-28-7781 65 **Director** 01-/01-/1946 Delaware Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🔀 No Salisbury Maryland Wicomico 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 409 Rolling Road 21801 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, permit. Page 1 and 2 should be filed within 72 hours after d Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or i any injury or other traumatic event, the Medical Examin Completed by 1 Never Married 2 K Married 1 Yes If Yes, Give 2 X No アラインタルアン アーセルト当 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Attorney Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Henry Lee Vinyard Sr. Velma Argo 19a. Informant's Name/Relationship (Type, Print)
Phyllis Vinyard/spouse 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 Rolling Rd., Salisbury, MD 21801 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Barrett's Chapel
Cemetery 1 K Burial 2 Cremation 3 Removal from State 3/18/2011 Frederica, DE 4 Denation 5 Other (Specify) 22. Name and Address of Facility
HOTIOWAY Funeral Home Professional Association Snow Hill Rd., Salisbury, MD 21804 1. Enter the disease, or complications that cau ock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ediate Cause (Final Ph_sician/ LUNG CANCELL ease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter University Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician the burial Physician/Medical Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown as been signal to 2 should to Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy page death? Yes Z No 1 Yes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) Hospital 27 No 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specifit SV1 C/3 After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tifle of certifier 29c. License number DO058410 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15 u C. Huyon 31. Date filed (Month, Day, Year) 32. Registrar's Signature State THE Registrar

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day 17,2°01 4:15P Gloria Winebrenner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Saint Joseph Medical Center Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year, arch 9, 1 1 □ M 2 🛛 F Months Days Hours Min. Maryland **Director** 214-34-2498 74 March Usual Residence of Decedent show 10b. County 10a. State 10c. City, Town or Location iral", or items 23a or 28a-f sho Examiner must be notified at 10d. Inside City Limits Director 1 🗌 Yes 2 🗶 No Maryland <u>Keedysville</u> Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 4102 Chestnut Grove Road U.S.A. 21756 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc 1 Never Married 2 Married "natural", or Š Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: Completed 3 X Widowed 4 □ Divorced Year or Dates White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Il Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Manufacturing Secretary permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic event 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Harry H. Abbott Marie Virginia Rohrer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Curt D. Winebrenner / Son Reisterstown, Bonfire Drive 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Mt. View Cemetery 03/23/2011 | Sharpsburg, Maryland 4 Donation 5 Other (Specify) Signature of Faneral Service Licensee 22. Name and Address of Facility Bast-Stauffer Funeral Home, PA 7606 Old National Pike Boonsboro, MD 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Physician/ STAGE RENAL DISEASE SECONDARY disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner HYPERTENSION Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): physician and s the burial-transit death certificate be executed SECONDARY TO PLEURAL 3 DAYS HYPOXIA that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical as 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by be det 23e. Did tobacco use contribute to the cause of death? ρ Records, BILATERAL ABOVE KNEE AMPUTATION FOR 1 ☐ Yes 2 📈 No 3 ☐ Probably 4 ☐ Unknown Completed PERIPHERAL VASCULAR DISEASE Were autopsy findings available prior to completion of cause of 24a. Was an certificate has be irector, page 2 s autopsy performed? Yes 2 No death? PERICARDIAL EFFUSION 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 K No ျ 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of nin 24 hours after death.

the Funeral Director: After inpleted filled in by the funer. Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending Division 1 🗌 Yes 2 🗌 No 2 Accident 3 Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MARCH 17,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3H-20 SMITH. OSLER DRIVE MARYL AND ATHERINE M.D 32. R gistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Box 68760

of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day}2011 Physician/ A M <u>Alice</u> Irene Gibson Ward March 5:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Calvert Memorial Hospital Calvert Prince Frederick 8. Date of Birth (Month, Day, Year) 07-31-1922 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🏋 F Maryland Director 88 216-18**-**9075 Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 1 No MD Calvert Owings 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö an "natural", or items 23a or Medical Examiner must be Funeral 9150 Southern Maryland Boulevard 20736 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. δ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: Completed 3 Widowed 4 X Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) d 2 should be filed within 72 lath and Mental Hygiene.
27 is marked other than "r traumatic event, the Med Elementary/Seconday (0-12) College (1-4 or 5+) bookkeeper banking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Joseph Gibson Irene Bowen John Virginia 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health at Important: If item 27 is any injury or other tran Alice Joan Dickerson, daugh. 9140 So. MD Blvd., Owings, MD 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Burial 2 ☐ Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) 03-23-2011 Owings, MD Harmony Cemetery 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Rausch Funeral Home, P.A. 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Htheroscienatic Cardio Vasular disense disease or condition Medical resulting in death) **Examiner** Cardio Vescular direase Hypertensive Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 yes, outcome of pregnancy

☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy
☐ Pregnant at time of death 5 ☐ Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? tor: After this certificate has been signed by the atter the funeral director, page 2 should be detached for Month Year Day 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Obstructive airway Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an tibrillo tion autopsy performed? 2 W No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director, After this or 1 Inpatient 2 FR/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending Investigation Accident 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number completed filled in by determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D. 50653 conq-GVAN . C. Surcence. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5851 Dece)e Road Deale min 31. Date filed (Month, Day, Year) 32. Registra s Signature State Registrar

Baltimore, Maryland 21215-0036 Box 68760 Records,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day 2011 8:25 P M MARCH 06, ROBIN DENISE WALLACE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner OUEEN ANNE'S** 1652 BARCLAY ROAD BARCLAY If Under 1 Year Months Days If Under 24 Hrs. Hours Min. 8. Date of Birth Social Security Numbe 7. Age (In vrs. last birthday 9. Birthplace (State or Foreign **Funeral** 1 □ M 2 🟋 F Months 12/21/1959 MARYLAND Director 218-82-4334 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a State 10c. City. Town or Location 10d, Inside City Limits Director 1 X Yes 2 No **QUEEN ANNE'S** BARCLAY MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral UNITED STATES 21607 1652 BARCLAY ROAD Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12 Was Decedent Ever in LLS 14. Race - American Indian Armed Forces? Black, White, etc. ģ 1 Never Married 2 M Married should be filed within 72 hours after 1 ☐ Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 Divorced WHITE the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DANCE INSTRUCTOR Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Malden Surname) n and Mental H ည ALMA KIRKPATRICK FRANCIS J. MURPHY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Page 1 and 2 strengent of Health a tant: If item 27 is 1652 BARCLAY ROAD BARCLAY, MARYLAND 21607 WILLIAM WALLACE / HUSBAND 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Important: If it any injury or o 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MARYLAND CHESAPEAKE CREMATION 03/11/2011 Signature of Funeral Service Lic 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL
130 SPEER ROAD CHESTERTOWN, MARYLAND 23a. Part 1. Enter the disease, or complications that caused the d shock, or heart failure. List only one cause on each line ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) O months Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): Physician/Medical use as 1 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ signed by the atter in the past 12 months?

1 Yes 2 No Month Day Year 1 Yes 2 9 Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pstructive 1 Yes 2 No 3 Probably 4 Unknown page 2 should Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 2 No Yes Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Yes 2 L No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 KResidence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending work 1 Natural injury after death. 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State) To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 XCertifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and 29d. Date signed (Month. Day, Year)

DHMH 17 Rev 7/2009

State Registrar

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Division of Vital

30. Name and address of person who completed cause of death (Item 23a) (Tobe, Frint)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ March 1^{Pgy} 2011 2:48 Рм Laura Maria Wiessner Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick Frederick Frederick Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Jan 28, Year) 1 M 2 K F Months 85 212-50-5058 Italy Director Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b County 10c. City, Town or Location 10d. Inside City Limits Director Taneytown Maryland Carroll 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? Funeral 414 Clubside Drive 21787 USA 11. Marital Status 12. Was Decedent Ever in U.S Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian. Armed Force Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🗶 No ۵ Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give white 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry should be filed within 72 hand Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Grocery Store Bakery Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Carolina Merli Roberto Sarti permit. Page 1 and 2 should I Department of Health and Me Important: If item 27 is marl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 414 Clubside Drive, Taneytown, MD 21787 Sandra A. Murray, daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lake View Memorial PK 3/23/2011 any injury or Sykesville, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home 136 E Baltimore St, Taneytown, MD 21787 K.7 LORAU 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ neumania disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami that the death certificate be executed the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): physician Physician/Medical Box 68760 inding puse as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? for Month Day Year Pregnant at time of death 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by lung Jobable Cancer Records, 1 Yes 2 No 3 Probably 4 Unknown 2 should 24b. Were autopsy findings available prior to completion of cause of Fibrillation 24a. Was an autonsy page death? Coagulopathy
25. Was case referred to medical 1 Yes 2 No Yes 2 No Division of Vital Be 26. Place of Death (Check only one) Hospital 2 No Other: ပု 1 Yes 1 Despatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury Natural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 🖺 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the I within 2 only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 060917 3-20-2011 WJL MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick MD 21702 65C Itemen shah Thomas Tulinson

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ Lawrence Thomas Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Westminster Carroll Hospital Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days **Director** 65 4/8/1945 <u>207-34-3529</u> PA. Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location within 72 hours after death with the Maryland Director Glyndon MD Baltimore 1 🗆 Yes 2 😾 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 21136 Funeral 4610 Prospect Ave. USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Armed Forces?

Armed Forces?

Yes 2 \sum No

If Yes, Give
Year or Dates. Black, White, etc. þ "natural", or 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2 ☑ No Specify: Completed 3 Divorced permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) electrical PMI Electrical engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Thomas L. Williams Florence Hamilton 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua L. Williams, son 374 8th St., Apt. 3 Atlantic Beach, FL 32233 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll 3/18/2011 Cremation Hampstead, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility M00741 Eline Funeral Home Lemmer Main Hampstead, MD 21074 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death abnormalities Immediate Cause (Final Physician/ Electroly disease or condition resulting in death) Medical **Examiner** 24 hours Acute reno Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Examir 24 hous ng physician and as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cardiac that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ jo in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death been signed by the a should be detached Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð Records, 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28c. Injury at work? 28a. Date of injury 28b. Time of Certificate: 28d. Describe how Injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide
Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier WJL D0064732 10+1VA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Britos-Bray Martin F-Westminster 200 Ave Mamorial 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 18. 2011 ar Marche В. wolfe 0235 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Rockville Montgomery Casey House 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days Months 1 □ M 2 🗓 F Hours Min. Washington. DC (Month, Pay, Year) 11 Director 99 577-01-6938 Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Gaithersburg Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 300 Russell Avenue 20877 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 Divorced Caucasian Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Sales 12 Retail permit Page 1 and 2 should be filed w Department of Health and Mental Hyg Important: If item 27 is marked othe any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Basil Basiliko Calliope Papazoglue 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4108 Brookeville Road, Brookeville, Maryland 20833 Robert Wolfe - Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🗓 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) Gate of Heaven Cem. 03/22/2011 | Silver Spring, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD 20904 23a. Part 1. Enter the disea e, or shock, or heart failure. List or omplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, by one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician/ Acute Respiratory Failure Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter charming Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of): Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 🕱 No Pregnant at time of death Month 1 ☐ Yes 2 ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed I 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, Pneumonia 1 Tes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 X No After this certificate har funeral director, page death? 25. Was case referred to medica examiner? 26. Place of Death (Check only one) Other: 4 \square Nursing Home 5 \square Residence 6 \square Other (Specify) Hospice 1 Tes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After the 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury X Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 ☐ Yes 2 ☐ No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated only one) 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatoxe and title of certifie 29c. License number R143201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Debrah Miller. CRNP, 6001 Muncaster Mill Road, Rockville, Maryland 20850 31. Date filed (Month, Day, Year) / 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

MAR 21 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Emma Elizabeth Waters Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** HICONICO REGIONAL 5AUS641 TENINSULA Social Security Number 6. Sex If Unde Year If Under 24 Hrs 8. Date of Birth DE Country) 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 □ M 2**X** F Months Days Hours Director 66 2<u>14-42-7606</u> Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location Director 1 ☐ Yes 🚻 No Westover MD Somerset 10f. Zip Code 10e, Street and Number 10g. Citizen of What Country? Funeral 37640 Costen Road USA 21871 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Race - American Indian, Black, White, etc. Armed Force þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 Speci**B**lack 1 ☐ Yes 2 X No Completed 3 Widowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Housekeeping/ Elementary/Seconday (0-12) College (1-4 or 5+) Domestic Laborer <u> Homemaker</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Robert R. Maddox Gladys Mae Horsey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Wilmington, DE 19808 5515-16 Limeric Circle, <u>Forest Hayward/Son</u> 20b. Place of Disposition (Name of cemetery, crematory or other biates) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 🗆 Burial 2 Cremation 3 🗆 Removal from State Direct Crematory, 3-17-2011 Dover, DE 4 ☐ Donation 5 ☐ Other (Specify) of Euper Service Li Bennie Smith 917 W. Isabella St. Funeral Home Salisbury, MD 21801 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failufe. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of To the Hospitallor Attending Physician: The law requires that the death certificate be executed and the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last the attending physician hed for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Dav Year Pregnant at time of death 2 🗆 No this certificate has been signed by the a ral director, page 2 should be detached g Unknown g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? 1 Yes 2 No Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) æ examiner? Hospital 2 4 No 1 🗌 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours fler death.

To the Funeral Director: After Natural (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No 5 Pending ☐ Accident Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, filled in by determined building, etc. (Specify) City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

State Registrar 30. Name and add

31. Date filed (Month, Day, Year)

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ss of person who completed cause of death (Item 23a) (Type, Print)

1640

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death March Physician/ 05 05 2011 Alice Mae Williams 1605 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Worcester Atlantic General Hospital Berlin 9. Birthplace (State or Foreign 8. Date of Birth 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. **Funeral** May 29 Country) 1 M 2 V F Director 217-28-3937 78 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Merdal Hygiene. Important: I fire Z is a marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d, Inside City Limits 10b. County 10c. City, Town or Location 10a, State Director 1 XYes 2 No MD Worcester Berlin 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Completed by Funeral 21811 USA 201 Maple Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11 Marital Status Black, White, etc.
African-1 Never Married 2 Married 1 Yes 2 If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2 X No Specify 3 XWidowed 4 Divorced American Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Poultry Line Worker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Sarah Adkins Able Young, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 838 W. Main St., Salisbury, MD 21802 William Young/brother Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Calvary UMC Cemetery: 3/11/2011 Berlin, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Lewis N. Watson Funeral Home, PA 1618 West Rd., Salisbury, MD 23a. Part 1. Eugenia sease, or complications that caused shock, or heart failure. List only one cause on each line. isease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Auntic Thy-acic disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of, for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box (3 Ctopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death a 🗌 Unknown 9 Unknown s been signed by i should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has autopsy page 2 performed² 1 Tes 2 No Yes 2 No Hospital or Attending Physician: 724 hours after death. Funeral Director: After this certifica within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ð 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural Division 1 ☐ Yes 2 ☑ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0070150 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of dd OCEAN CI 10445 Gibbs 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

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DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year Physician/ ROBERT MARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FREDERICK MEMORIAL FREDERICK 5. Social Security Number 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Months Days Hours 50 214-80-**7**826 Director Washington, DC Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 🗓 No New Market Frederick MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21774 United States 5716 Yeagertown Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14 Bace - American Indian. 11. Marital Status rmed Forces Yes 2 Black, White, etc 1 Never Married 2 Married þ 2 \(\text{N} Maryland 21215-0036 If Yes, Give Year or Dates. 1 ☐ Yes 2 🔀 No Specify: White 1979-81 3 Divorced 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Bricklayer Construction Should be filed with h and Mental Hygien 7 is marked other t Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev မ Eva Culler Samuel Ralph Wahl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5716 Yeagertown Rd., New Market, MD 21774 Eva Wahl / mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Smithsburg Crematory 03/30/2011 Smithsburg, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Keeney & Basford Funeral Home 21. Signature of Funeral Service Licenses · Garpeline Kre MO1222 106 E. Church St., Frederick, MD 21701 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) u to (or as a consequence of) Examiner rrho Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of): nding physician /Medical the Hospital or Attending Physician: The law requires that the death certificate be Box 68760 the th as IF FEMALE use s, outcome of pregnancy Physician/ 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy atten for u in the past 12 months?
1 Yes 2 No Year 5 Other (specify) Month Day Pregnant at time of death the Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Records, 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an After this certificate has funeral director, page 2 autopsy Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Yes ျ 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred injury 1X Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) cal 🛣 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 2011 MDD 35106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick mo 100 31. Date filed (Morith, Day, Year) 32. Registraris Signature State

Registrar

APR 0 4 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 17, Day 2011 Year Leona Catherine Wiles March 2:55 Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Glade Valley Nursing & Rehab Center Walkersville Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs,
Months Days Hours Min. 8. Date of Birth Funeral 9. Birthplace (State or Foreign 1 M 2 X Months Apr. 1917 214-32-4690 93 Maf VI and **Director** Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Adams Fairfield 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Dandelion Trail 17320 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No If Yes, Give Specify: White 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Charles Linton Pearl Kintz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Dandelion Trail, Fairfield, PA 17320 Paul Wiles Sr. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Clustard Spires Cem. 3/22/2011 4 ☐ Donation 5 ☐ Other (Specify) Frederick, Maryland Reeney & Basford P.A. Funeral Home 106 E. Church St., Frederick, MD 21701 21. Signature of Funeral Service Licensee MO1612 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) neumoni Medical Due to r as a consequence of Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed ending physician and use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Pregnant at time of death Day signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à bronobertous Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an blood Pressure autopsy 1 🗆 Yes 2 🗖 No 1 ☐ Yes 2 🗶 No 25. Was case referred to medical within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Certificate: To I 1 Tyes Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural work?
1 Yes 2 No 5 Pending injury Accident Investigation 3 Suicide
4 Homicide Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check and title of certifier 29b. Signaturg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thomas 1600 son APR 0 1 2011

DHMH 17 Rev 7/2009

Registrar

State of Maryland / Department of Health and Mental Hygieney For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ P^{M} WATERS :55 ELEANOR March Medical MAE 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Frederick Frederick Memorial Hospital Frederick 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 🗶 F Months Davs Hours Min. May 6, Day 1937 Maryland **Director** 214-70-0176 Usual Residence of Decedent or 28a-f show notified at 10b. County 10d. Inside City Limits 10a. State 10c. City. Town or Location death with the Maryland Director 1 X Yes 2 No Maryland Frederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r must be r Funeral <u>United States</u> 110 Burgess Hill Way 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No- Race - American Indian Black, White, etc. 11. Marital Status "natural", or ite Armed Forces?

1 Yes 2 X No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married þ within 72 hours after Maryland 21215-0036 Specify: White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Driver Public Schools Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) th and Mental H 27 is marked or traumatic eve ပ Frances Redman Jesse Fox and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>874 Mego Vista Road, Arnold, Maryland 21012</u> <u> Jill Manahan / Daughter</u> other Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of H
Important: If ite
any injury or oth March 28, Page 1 cemetery, crematory or other place) 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Smithsburg Crematory 2011 Smithsburg, Maryland re of Funeral Service Vicensee Keeney and Basford PA Funeral Home, Maryland 21701 MO1473 106 East Church Street, Frederick, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disea shock, or heart failurg Immediate Cause (Final Physician/ VENTRICULAR FIBRILLATION disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine FIBRILLATION death certificate be executed MBOLI FROM and burial-trar Due to (or as a consequence of) attending physician Physician/Medical 68760 the for use as yes, outcome of pregnancy
Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Box Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 🔀 No Month 5 Other (specify) Day Year Pregnant at time of death be detached Unknown P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 death? this certificate 2 🗌 No Hospital or Attending Physician: funeral director, 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 X No ျ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred After injury 1 X Natural 5 Pending 2 No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 within 2 To the F only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year, D0065429 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 15225 SHADY GROVERD, ROCKVILLE, MD 17. nth, Day, Year) State 4 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Martha Lou Young 0955 AM March 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Hagerstown Washington County Social Security Number 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Feb. 17,1930 1 □ M 2 🕅 F Days Hours Min. 212-24-3656 Maryland Director Usual Residence of Decedent or 28a-f shov 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director Maryland Washington County Hagerstown 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 18919 Dover Dr. 21742 U.S.A. death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black. White, etc. or i 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No If Yes, Give 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White and Mental Hygiene. is marked other than "natural", 3 XWidowed 4 ☐ Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 15. Decedent's Education 16b. Kind of Business Industry 16a Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Board of Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Herbert Whipp Alma S. Wooley Whipp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1902 Shawan Valley Lane Huntvalley, MD 21136 Rebecca Reeves-daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State Rest Haven Cemetery 3-19-2011 Hagerstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Douglas A. Fiery Funeral Home Eastern Blvd. North Hagerstown. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or conditions) Interval Between Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine and -transit Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 month Day Pregnant at time of death been signed by the should be detached 9 Unknown 9 Unknown Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autonsy page this certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be director, Hospital: Other: 2 No 1 🗌 Yes ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work? Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) ☐ Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🖂 To the within 2. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of ce of person who completed cause of death (Item 23a) (Type, Print) 3H6-L Medical Car State

Registrar

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· 89	Physici	an	Decedent's Name (First, Middle, Last) LASHAUN ELIZA	DEMU VOLIN	C			2. Date of Dea Month MARCH	1 7 201 1 Year	3. Time of Death 5:25AMM
• T	/Medic Examin		4a. Facility Name (If not institution, give st GLADYS SPELLM	reet and number)	<u> </u>	4b. City, Town, o	r Location of De		4c. County of Dea	th
	Funeral Director		311 10 0110	M ¾□ F 7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days		Hrs. 8. Date of Birt	9. Bi 956 WAS	thplace (State or Foreign ountry) SH . D . C .
	nyland thow		Usual Residence of Decedent 10a. State 10b. County		City, Town or Lo					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f	ecto	MD P.G.		FOREST				10g. Citizen of What C	
	with t	2	10e. Street and Number 1300 EASTWOOD I	OP TUE		10f. Zip Code	0747		USA	outility:
10	72 hours after death with the Maryland natural', or items 23s or 28s-f show lical Examinational be redified at	Funeral Director		2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☐ No		Was Decedent of H If Yes, specify Cuba	lispanic Origin? an, Mexican, Pi	? (Specify Yes or No- uerto Rican, etc.)	- 14. Race - Am Black, Wh	ite, etc.
036	ours a	þ	3 ☐ Widowed 4 ADivorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:		Specify: BI	
1215-0		Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation completed) College (1-4or 5+)	16a. Dece (Give life.	dent's Usual Occup kind of work done DO NOT use retired CLER	during most of d)	working	16b. Kind of Busines:	,
Maryland 21215-0036	be filed ital Hyg id othe event,	To Be Co	17. Father's Name (First, Middle, Last) LAWRENCE YOUNG	3				Name (First, Middle,		
Mary	s 1 and 2 should be t Health and Mental Item 27 is marked other traumatic ev		19a. Informant's Name/Relationship (Typ		1				er, City or Town, State. ILLE, MD.	
Baltimore,	m 0		20a. Method of Disposition 1 ☼ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	20	b. Place of Dispo cemetery, cre	osition (Name of matory or other plai IILL CEM	ce)	Date	20c. Location - City o	r Town, State
Baltir	permit. Page Department of Important: If any injury or once.	4 Donation 5 Dotter (Specify)						20010 SH. DC.		
			23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.					rrest,	Approximate Interval Between Onset and Death
	Physician /Medical Examiner		disease or condition resulting in death)	MULTIPLE Due to (or as a con-		COVASCUL	AR ACC	CIDENI		
p. S	ed sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con-	sequence of).					
8760,	ate be executed oblysicien and the burial-transit	ical Examiner	that initiated events content of the	Due to (or as a con-	sequence of);					
O. Box 6	death certific e attending pi ed for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	Sc. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time 9 Unknown	etal death 3	□Ectopic pregnance□ Other (specify)	y		23d. Date of d Month	elivery Day Year
ds, P	es tha gned be de	b	Part II. Other significant conditions conditions HYPERTENSION	tributing to death but not	resulting in the u	underlying cause giv	ven in Part I.		obacco use contribute Yes 2 □ No 3 □ I	to the cause of death? Probably 4 Julnknown
Records,	e de	Completed	DIABETES MELLI	TUS				24a. Was auto pendo 1 Yes	psy prior to prmed? death?	
Vital	ian: T	BeC	25. Was case referred to medical				26. Place of	Death (Check only of		
of V	Physician: this certific ral director.	2	I Tes 222 No	ospital: 1 🗆 Inpatient :					dence 6 □Other (Sp	pecify)
	Attending P r death. sctor: After t by the funera	ation:	27. Manner of Death 1 XNatural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wo	ryat rk? ∣Yes 2 □ No		how intury occurred	
Division	- 0	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Ptace of Injury - A building, etc. (Sp	At home, farm, st ecify)	reet, factory, office		28f. Location (City or To	Street and Number or wn, State)	Rural Route Number,
	To the Hospital o within 24 hours aff To the Funeral DI completely filled in	Medical	29a. Certifier (Check only one) 1 XCertifying Phys 2 Medical Examin	icien: To the best of my er: On the basis of exam and manner stated.	knowledge, dea nination and/or in	th occurred at the travestigation, in my	me, date and p opinion, death o	place, and due to the occurred at the time,	cause(s) and manner date and place, and d	as stated. ue to the cause(s)
)	To the To the comp	×	29b. Signature and title of certifier	run	Ly	29c. Licens	se number 6278	MD.	29d. Date signed (Mg	nth, Day, Year)
	6		30. Name and address of person who cou REVATHY MURTHY				CHEVI	ERLY, MD	. 20785	
	Sta Regist		31. Date filed (Month, Day, Year) MAR 2 2 2011	'32. Registrar's S	ignature Sack	,				

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20b,c per fh g914 4-7-11 vt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ PM loa i 2:1 201 139 A Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Saltimor mm 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🗹 F Hours -33-678 Yrs. Director Usual Residence of Decedent 10b. County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 THO Ymore HMORE 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 1154 21228 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. 1 ☑ Never Married 2 ☐ Married Completed by Yes 2 No Baltimore, Maryland 21215-0036 1 MYes 2 □ No Specify. If Yes, Give 3 Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) Mother's Name (First, Middle Maiden Surname) 18 ၉ aria 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Ryral Route Number, City or Town, State, Zip Code) MD21208 Place of Disposition (Name of come Goodna Shop presented) 20a. Method of Disposition 20b. Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 7-2011 22. Name and Address of Facility Signature of Funeral Service Licenses Load Kanda 23a. Part 1. Imper the disease, in complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Ederic Physician/ 55.41 Medical Due to (or as a consequence of): 36 hours Examiner tracce bre MON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner ue to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury win Communica attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Yea 5 Other (specify) Pregnant Unknown Pregnant at time of death 1 Yes 2 9 Unknown signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ğ 1 Tes 2 № No 3 □ Probably 4 □ Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an sate has bage 2 s autopsy ا 24 hours after death. • Funeral Director: After this certificate ا Yes 2 X No 25. Was case referred to medica 26. Place of Death (Check only one) æ examiner? Other: 1 \square Yes 2 🔊 No ဂ္ဂ 1 X Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Deatl 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 28d. Describe how injury occurred 1 X Natural 5 Pending injury 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 29c. License number 2011 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) randall Greene St 21201 5. W Kenneth 77 31. Date filed (Month, Day, Year) . Registrar's Signat re State APR 05 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03-31-2011 Ricardo O. Amoroso 1405 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Harford Upper Chesapeake Medical Center Bel Air 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 🛛 M 2 🗆 F Hours Min. 12 Marty Day 936 213-34-4444 Director Usual Residence of Decedent or 28a-f show 10a, State 10b. County 10d. Inside City Limits 10c. City. Town or Location death with the Maryland Funeral Director 1 Tes 2 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or items 23a of the Medical Examiner must be 120 W. Broadway #D USA 21014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hygiene. Important: If item 27 is marked other trainany injury or other trainance. Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3 Divorced 4 Divorced Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Carpenter Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Unknown Martha Amoroso 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Marie Amoroso (Wife) 120 W. Broadway #D Bel Air, MD 21014 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Highview Mem. Gardens 04-04-2011 4 ☐ Donation 5 ☐ Other (Specify) Fallston, MD 21. Signature Fig. | Service L 22. Name and Address of Facility Schimunek Funeral Home of BelAir Inc 610 W. MacPhail Rd BelAir, MD 21014 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): < 24hrs Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 ☐ Yes 2 ☐ No Pregnant at time of death 9 Unknown g Unknown To the Hospital or Attending Physician: The law requires that the within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the completed filled in by the funeral director, page 2 should be deteched. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? , immunasuppression transplant 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy
performed?

Yes 2 No 1 Yes 2 No Be (25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 ☐ Yes 2 ₺No Other: ပ 1 Pinpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical 29a. Certifier 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of 29c. License number 31,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Knaral 500 Upper Checapeake Drive Bel Air, mo 21014 State Registrar

M00010345

11-02321 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Sarah Aryeequaye 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician/ March 25, 2011 0945 hrs Medical Examiner Sarah Naa Ayele Aryeequaye 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Laure Prince George's Laurel Regional Hospital If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days Hours Months Director Country) Maryland 218-89-0898 2XXF 2010 1 M Dec 18, Usual Residence of Decedent 10d. Inside City Limits uny 10a State 10c. City. Town or Location 1 X Yes 2 No MD 28a-f show Prince George's Laurel tem 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at once. Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygeine.
Important: If item 27 is marked other than "natural", or items 23a no 28a-7 sho Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14104 Bramble Court 20708 U.S.A. Funera 11. Marital Status Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, "natural", or items If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? White, etc 1 XXNever Married 2 Married African Yes If Yes, Give Yeer 1 Yes 2 XXNo specify: 3 Widowed 4 Divorced Specify: American 2 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) N/A N/A N/A N/A 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Edward Aryeequaye Imomotimi Oyabaragha 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Imomotimi Oyabaraqha / mother 14104 Bramble Court Laurel, Maryland 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 20a. Method of Disposition crematory or other place) 1 XXBurial 2 Cremation 3 Removal from State Ivy Hill Cemetery 4/1/2011 Laurel, Maryland 4 Donation 5 Other Specify: 22 Name and Address of Facility
Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licensee M00770 313 Talbott Avenue Laurel, Maryland 20707 **Physician** 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Between Onset and failure. List only one cause on each line /Medical Death a. Head and Neck Injuries Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last signed by the attending physician and i be detached for use as the burial - transit sician/Medical UNPENDED AMENDED Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Month Year Fetal death Day 2 past 12 months? 4 Pregnant at time of death 5 Other (Specify) 1 Yes 2 ✔ No 9 Unknown 9 Unknown contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š 1 Yes 2 ✓ No 3 Probably 4 Unknown Completed page 2 should has been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? 1 🗸 Yes ✓ Yes 2 No this certificate 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other Nursing Home 5 Residence 6 Other 2 FR/Outpatient 3 DOA 1 🗸 Yes 2 No 28a. Date of Injury 28c. Injury at Work? After 27. Manner of Death 28b. Time of Injury 28d. Describe how injury occurred Mar 25, 2011 Infant struck by vehicle while being held in 1 Natural 0908 hrs Pending 1 Yes 2 ✔ No Director: hours after death. mother's arms 2 🗸 Accident Investigation filled in by 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 Could not be or Town, State) 8314 Montpelier Drive, Laurel, MD Certi thin 24 hours af determined (Specify) Local Street 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 27, 2011 30, Name and address of person who completed cause of death (Item 23a) Donna M. Vincenti, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

Registrar DHMH 17 Rev 1/2001 **OCME 2006**

State

31. Date filed (Month, Day, Year)

05

OCME

32. Registrar's Signature

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Catherine Stella Anuszewski April Physician/ 2011 2. 3:30 A Medical 4c. County of Death N/A 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner St. Elizabeth Rehabilitation & Nursing Center Baltimore ocial Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 216-05-6467 1 M 2 🕮 F Months Days Hours Min Feb. 8, 1918 Maryland Director Usual Residence of Decedent show 10b. County 10d. Inside City Limits at 10a State 10c. City, Town or Location Director must be notified N/A Maryland **Baltimore** 28a-f 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Numbe ō 613 Annabel Avenue 21225 23a Funeral USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Examiner Armed Forces?

1 Yes 2 X No Black, White, etc. 5 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 Page 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 X No Specify: White If Yes, Give Year or Dates "natural", 3 X Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Harbor Hospital Center Seamstress the Ith and Mental Hygie 27 is marked other r traumatic event, th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Stanislaus Pajak ပ Victoria Gwalina 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7949 Pipers Path, Glen Burnie, Maryland 21061 Patricia L, Maufer of Health a (Daughter) other 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date 1 X Burial 2 Cremation 3 Removal from State Holy Cross Cemetery ŏ Baltimore, Maryland Department o Important: If any injury or once. 4/6/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility Moully-Folyniak Funeral Rome, P.A. Signature of Funeral Service Licensee Kevin E Fcker 237 E. Patapsco Ave., Baltimore, Maryland 21225-1856 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ everal , disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine burial-transit and Due to (or as a consequence of) resulting in death) Last physician sthe burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death ate has been signed by the apage 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by CHRONIC ATRIAL FIBRILATION, MYPOTHYRODING 1 - Yes 2 No 3 - Probably 4 - Unknown 24b. Were autopsy findings available prior to completion of cause of death? CONCESTIVE HEART FAILURE, 24a Was an autopsy performed? Yes 2 No DEMENTIA - END STAGE ALZHEIMER'S 1 ☐ Yes 2 X No 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner? Other: 4 Mursing Home 5 - Residence 6 - Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA After this within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certific 29d. Date signed (Month. Day, Year) gral D0018362 KOMAL K. DANGM.D. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ste 3455, WILKENS L10. BALTO. MD 21229 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ tarrie + Allen 5:45-AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Charlestown Care Center Catonsville 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🕱 F Months Davs Hours Min. 9/17/1921 Country)
Maryland 214-12-2218 Director 89 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits death with the Maryland Director Baltimore 1 Yes 2 X No MD Catonsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 719 Maiden Choice Lane, BR 409 21228 USA 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, "natural", or iter Black, White, etc. ō 1 Never Married 2 Married Completed by ☐ Yes 2 🂢 No be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates 3 🕅 Widowed 4 □ Divorced White 27 is marked other than "natur traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher County School System Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Samuel Morris Nellie Belt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 4004 Wilkinson Road, Harve de Grace, MD 21078 Barbara E. Ringers / POA 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite 1 Burial 2 X Cremation 3 Removal from State injury or 4/5/2011 Bayview Crematory Baltimore, Maryland Donation 5 Other (Specify) 22. Name and Address of Facility Hubbard Funeral Home, Inc. Signature of Funeral Service Licensee 4107 Wilkens Avenue, Baltimore, Maryland 21229 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Pulmonary Disease Physician/ Chronic disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed physician and the burial-transit Due to (or as a consequence of): Physician/Medical Box 68760 nding દ કe as ti IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No for Month Year Day Pregnant at time of death
Unknown has been signed by the e 2 should be detached g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No certificate 25. Was case referred to medical Division of Vital 26. Place of Death (Check only one) Be 2 No Other: 4 Vursing Home 5 Residence 6 Other (Specify) 1 Yes မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Hospital or Attending I 24 hours after death. Natural To the Hospital or Attending within 24 hours after death.

To the Funeral Director: Afte completed filled in by the fun 5 Pending 1 Yes 2 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Letrifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated ロッソ377 mp 12V 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 711 Maid Registrar's Signatur Maiden Choice Lune 31. Date filed (Month, Day, Year) 32. State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death April Physician/ 03 Spindler Aburn 2011 8:03 P M George Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Towson Gilchrist Date of L... (Month, Day, Y 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last hirthday 8. Date of Birth **Funeral** Hours Min. 1 **X** M 2 □ F Maryland Director 220-20-3732 84 Jan. Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Towson MD. Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21286 800 Southerly Rd. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. ģ 1 Never Married 2X Married 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify. White Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work dane during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 | th and Mental Hygiene. 7 is marked other than "r. College (1-4 or 5+) 5+ Elementary/Seconday (0-12) Black & Decker Sales & Marketing Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Eleanor Spindler Herbert Oger Aburn 19a. Informant's Name/Relationship (Type, Print) permit. Page 1 and 2 st.
Department of Health an,
Important: If item 27 is m
any injury or other 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9814 Northbrook Ct. Ellicott City, MD. Mr. Clarke Aburn/ Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-8-11 Timonium, MD. Dulanev Vallev Mem. 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Ruck Towson Funeral Home, 1050 York Rd. Towson. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. nterval Between Immediate Cause (Final Onset and Death Physician/ ULmona marty disease or condition resulting in death) Medical **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of). that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Day is certificate has been signed by the a director, page 2 should be detached f Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 Yes Division of Vital | 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner? Other: 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral dir 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No ☐ Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Decrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one Signatu 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AMVES 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Maich ames 0 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Howard Ellicott City Ellicott City Health & Rehab If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Yes July 10, 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Year) 705-14-0301 Gountry) Mary land Director 1926 Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 and 2 should be filed within 72 hours after death with the Maryland f Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 No Catonsville Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21228 303 Maiden Choice Ln #105 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?
1 ☑ Yes 2 ☐ No 1944 Black, White, etc. 1 ☐ Never Married 2 🖔 Married Completed by Baltimore, Maryland 21215-0036 white If Yes, Give 1 ☐ Yes 2 X No Specify. 1956 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Martha Matilda Kelley John Alfred Abbott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Abbott, Jr. 2 Lawrence Brook Rd; Catonsville, Maryladn 21228 or other 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ot 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 22. Name and Address of Facility State Anatomy Board 21. Signature 1 leral ice 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Ener the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line.

Immediate Cause Final
disease or condition

a. Physician/ y ears Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any leading to in mediato cause. Enter Underlying Examine Day to for as a consequence off After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 If yes, outcome of pregnancy 1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months? Year Month Pregnant at time of death Day Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ ATRIAL FIBRILLATION 2 ENO 1 🗌 Yes 3 Probably 4 Unknown Completed CARDIOMYORATHY 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director After this certific completed filled in by the funeral director, 25. Was case referred to medical Certificate: To Be 26. Place of Death (Check only one) examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify, 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural Accident 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) APR 0 5 201 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien ? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Medical **Examiner** 4b. City, Town, or **Funeral** M 2 | F Months INFANT Director Usual Residence of Decedent 28a-f shov 10b. County other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director Yes 2 No 10f. Zip Code ò 10g. Citizen of What Country? Funeral 23a items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Never Married 2 Married Black, White, etc. "natural", or þ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working 2 should be filed within 72., the and Mental Hygiene.
7 is marked other than "r life. DO NOT use retired) College (1-4 or 5+) INFANT Elementary/Seconday (0-12) INFANT INFANT INFANT Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important; If item 27 is any injury or other trau nother Azizat Adalikwu Bowie, Md 2006 elilah 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 21. Sign nure Funer | Service Licensee Ronald S. W 22. Name and Address of Facility State Anatomy Board 655 W. Baltimore St; Baltimore, MD 21201 2011 Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, r heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) Physician/ remature) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence on). ng physician and as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physiciar Physician/Medical Box 68760 IF FEMALE: nse yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy ed by the atter detached for u in the past 12 months? Month Vear Day Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by the period of the signal of the si 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a. Was an has autopsy certificate director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 XX မ 1 Pnpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident injury 5 Pending work? 2 🗌 No Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. 4 Homicide determined Medical 29a. Certifier 🕯 🚅 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) the 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Medical 32. Registrar's State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April $1,201^{\text{y}}$ 4:45P. Mary Julia Bullen Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Balto. Gilchrist Hospice Care Towson Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days December e20,1945 New Jersey 1 🗆 M 2 😾 F 218-46-9336 65 **Director** Usual Residence of Decedent 28a-f shov filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 🗆 Yes 2 🔀 No Md. Balto. Kingsville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21087 USA 11803 Gontrum Road 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. White 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify "natural", Specify: Completed 3 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Firm 12 Bookkeeper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Clifford H. Borne Mary O. Gibel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11803 Gontrum Road Kingsville, Md. 21087 Robert H. Bullen, Sr. Spouse 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place)
Bayview 1 ☐ Burial 2 K Cremation 3 ☐ Removal from State 4-4-2011 Balto. Md. 4 ☐ Donation 5 ☐ Other (Specify) Schimunek Funeralliome Sig at re of Funeral Service Licensee 22. Name and Address of Facility 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Central Newous system now Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Day to for as a nunsequency of if any leading to immediate cause. Enter Underlying Exami Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last ttending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ctopic pregnancy
5 Other (specify) in the past 12 months? Month Day Pregnant at time of death Unknown 2 100 the page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à 2 N → 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy the Hospital or Attending Physician: The thin 24 hours after death.

the Funeral Director: After this certificate Impleted filled in by the funeral director, page 2 🗆 No Yes 2 4 1 Tyes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) → Specify 27. Manner Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 atural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, completed filled in by determined Medical 🗓 🚅 🚾 tifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 29b. Signature and title of certifier D0070635 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Pati Suite 4105 paltmone, MD 21204. N Charles 6701 31. Date filed (Month; Day, Year) 32. R distrar's Signature State Registrar

11-02469 Linda Mary Bank			or Print in Black of Maryland / Dep	partment			al Hygiene	2011	10727
Physicia		Registrar 1. Decedent's Name (First, Middle,La		erincate	OI Dealii		2. Date of Dea		3. Time of Death
Madical Examir		Linda Mary Banke	rt				Month March 30,		1823 hrs
		4a. Facility Name (if not institution, gi Harford Memorial Hospita			4b. City, Town Bel Air	n, or Location of	Death	4c. County of Death Harford	
Funeral		Social Security Number 6. S		s. last birthday		Year If Under	24Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bir	
Director		216-48-2238	M 2XF 63		Yrs. Months I	Days Hours	March	25,1948 Foreig	n untry)Maryland
à	ŀ	Usual Residence of Decedent 10a. State 10b. County	110c Ci	ity, Town or Lo	ocation				10d. Inside City Limits
d d d		Md. Balt		•	ingsvill	.e			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number			10f. Zip Coo	le	1	0g. Citizen of What Cou	ntry?
the Tiffe		11200 Sheradale	Drive		2108	37		USA	
r death with or items 2: must be n	Funeral	11. Marital Status 1 Never Married 2 Marrie	12. Was Decedent Ever in Armed Forces? 57				n? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - Ameri White, etc.	can Indian, Black,
ter dea			1 Yes 2 No	,	Yes 2X	No specify:		Specify: W	nite
ours af	<u>ق</u>	15. Decedent's Education (Specify of	or Dates:		dent's Usual Occi	upation (Give kir		16b. Kind of Business/	ndustry
11215-0036 Id be filed within 72 hours after frontal Hygiene. aarked other than "natural", event, the Medical Examiner	Completed	Elementery/Secondary (0-12)	College (1-4 or 5+)		memaker	Tille, DO NOT us	se retired)	Home	
-003 1 withingsene.	Ē.	17. Father's Name (First, Middle, Las		l no	memaker	18.Mother's	Name (First, Middle, I		· · · · ·
215 be filed ntal Hy rked of	-	Albert M. Dippel	,			Ann	a J. Weige	elt	
221 hould I nd Mer is man	리	19a. Informant's Name/Relationship (Type, Print)	19b. M a	iling Address (S	treet and Number	er or Rural Route Nun	nber, City or Town, State	, Zip Code)
nore, MD 2 ages I and 2 shou nt of Health and In it: Witem 27 is other traumatic	-	Amy Gray 20a. Method of Disposition	DTR.		37 Cedar		Road Dan	lington, Mo	1. 21034 Town, State
iore iges 1 g it of Ho ii. If it		1 Burial 2 Cremation 3	Removal from State	crematory o	r other place)		-4-2011	Balto Md.	
iltim nit. Pa artmen ortani	ŀ	4 Donation 5 Other Specification 21. Signature of Funeral Service Lice	·	New Cat	nedral 2. Name and Add			FuneralHor	ne
Balt permit Depart Impor		Mal			9705 Bel	air Roa		ngham, Md.	
Physician /Medical		23a. Part I. Enter the disease, or corn failure. List only one cause on e		ath. Do not ent	er the mode of dy	ing, such as care	diac or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Ceuse (Final disease or condition resulting in death)	Atherosclerotic Cardio		Disease				Death
		Sequentially list conditions,							
	mine	if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a consequence	∋ of):					
	Exan	events resulting in death) Last	Due to (or as a consequence	e of):					
execut an and all tran	<u>s</u>	UNPENDED	AMENDED						
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Box 68760, e death certificate be the attending physic ed for use as the bur	ysi	1 Yes 2 No 9 Unknow			Other (Specify)				
Records, P.O. Box 68760, The law requires that the death certificate be icate has been signed by the attending physici page 2 should be detached for use as the burings.	절	Part II. Other significant conditions	contributing to death but no	t resulting in th	he underlying cau	se given in Part		obacco use contribute to s 2 ✔ No 3 ☐ Prob	
duires	E E	Obesity					24a. Was		topsy findings available
COFC law re has be	Completed						autop		ompletion of cause of
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Vital ysiciar his cert directo	ď		Hospital: 1 Inpatient 2	✓ ER/Outpati		Othor CT		Residence 6 Other	:
Of ling Ph	⊢⊦	27. Manner of Death	28a. Date of Injury (Month, Day,Year)	28b. Time		Injury at Work?		now injury occurred	
Sion Attend death. cctor:	atio	2 Accident 5 Pending Investigat				Yes 2 N			
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the ra after death. The Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Could not determine		home, farm, s	street, factory, offic	ce building, etc.	28f. Location (S or Town, S	Street and Number or Ru tate)	ral Route Number, City
hou hou		4 Homicide	lian: To the best of my knowle	edge, death oc	ccurred at the time	, date and place	a, and due to the caus	e(s) and manner as state	ed.
Fo the within Co the complet	Medical	one) 2 Medicai Examine	COn the basis of examination and manner stated.	n and/or invest			rred at the time, date		
	Ž	29b. Signature and title of certifier	0/1/ma	D		ense number		29d. Date signed (Mor	nth, Day, Year)
		July - Sattle	Week	- 22-1	0.	C.M.E.		March 31, 2011	
,		Name and address of person who	completed cause of death (Ite	ein ∠3a)					

DHMH 17 Rev 1/2001 OCME 2006

State Registrar Victor Weedn MD JD

31. Date filed (Month, Day, Year)

ORIGINAL

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		For State Registrar	State of N	/laryland /		rtment of H ificate of D			/	011	10728
Physicia	an/	Decedent's Name (First, Midd	lle, Last)			mouto of B		2. Date of Dea		V	3. Time of Death
Medi	cal	Jack Bolton 4a. Facility Name (if not institution)	a sive atreet and number			41.07.7		March 3			9:19A. M
Exami	ner	13012 Easter				4b. City, Town, or	Location of Death		4c. 0	County of Deatl Balt	
Funeral Director		5. Social Security Number 556-34-6324		nge (In yrs. last b 79		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt May 26		9. Birt	hplace (State or Foreign Intry) Inois
and show i at	ō	Usual Residence of Decedent 10a. State 10b. Count	у	10c. City, To	wn or Loca	ation					10d. Inside City Limits
Maryl 28a-f iotifiec	irect	Md.	Balto.			Essex					1 ☐ Yes 2 🛣 No
vith the 23a or st be r	Funeral Director	10e. Street and Number	rn Awanua			10f. Zip Code 2122	n		10g. Citiz	en of What Co	untry?
death v items ner mu		11. Marital Status	12. Was Decedent	t Ever in U.S.	13. W	as Decedent of His	panic Origin? (Spe	cify Yes or No-	1	4. Race - Amer	
336 s after a al", or Examir	d by	1 ☐ Never Married 2 ☐ Ma 3 🕅 Widowed 4 ☐ Divorce		1950-19		Yes 2 No	Specify:	riioari, etc.,	s	Black, White pecify: Wh	
5-00	Completed	15. Deced (Specify only high	ent's Education nest grade completed)		6a. Decede	nt's Usual Occupa	tion uring most of worki	na	16b. Kin	d of Business I	ndustry
21215-0036 within 72 hours after giene. rer fhan "natural", o	Com	Elementary/Seconday (0-12)		5+)	life. DO	NOT use retired) rician		.9	West	tern E1	ectric
nd if led w tal Hyg	To Be	17. Father's Name (First, Middle,	,	-			18. Mother's Name	e (First, Middle,	Maiden St	urname)	
Iryla buld be d Meni marke	F	Floyd Bolt 19a. Informant's Name/Relation:			0. 14.75		Margaret				
od 2 sho salth an n 27 is er trau	3	Margaret Lem		TR.			nd Number or Rura n Avenue				Code)
Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any jointy or other traumatic event, the Medical Examiner must be notified at once.	1	20a. Method of Disposition 1 ☐ Burial 2X Cremation 4 ☐ Donation 5 ☐ Other			tery, crema	tion (Name of atory or other place) 1 1	4-1-2	Date D11		ation - City or	Town, State
Balt permit. Departi Import any inji	į. Į	21. Signature of Funeral Service	W			9705 Be1	of Facility Sch	Nott	ingha	cal Hom am,Md.	
Physician/	a s	23a. Part 1. Enter the disease, c shock, or heart failure. List Immediate Cause (Final disease or condition	or complications that cause only one cause on, ach li	ed the deal. Do			such as cardiac o				Approximate Interval Between Onset and Death
Medical Examiner		resulting in death) Sequentially list conditions,	Due to (or as	s a consequence		701010	0000				Tyears
State of the state	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	s a consequence	e of):						
760 Ke sate be executed physician and the burial-transit		that initiated events resulting in death) Last	C. Due to (or as	s a consequence	e of):						
760 ficate b g physic as the b	Nedical		d								
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal dea at time of death		Ectopic pregnancy Other (specify)			20	3d. Date of deli Month	very Day Year
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un of Vital Inding Physician: Tuth. After this certifice funeral director, is	e: To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 ☐ Inpa 28a. Date of inj		. Time of	28c. Injury	4 ∐ Nursing Hor at 2	ne 5 Anesid			<u></u>
ion (earth.	Certificate:	1 Natural 5 Pendi 2 Accident Invest 3 Suicide 6 Could	igation	ay, Year)	injury	work?	es 2□No		,	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
Division of Vital tal or Attending Physician: rs after death. al Director: After this certific ed in by the funeral director.		4 Homicide deterr	mined 28e. Place of In	jury - At home, tc. (Specify)	farm, stree	t, factory, office	2	28f. Location (Sa City or Town		Number or Rura	al Route Number,
the Hospita in 24 houn the Funera	Medical	only one) 3 Certifyin	Physician: To the best of examiner: On the basis of Nurse Practioner: To the	examination and	vor investic	ation, in my opinion	. death occurred at	the time, date ar	id place a	indidue to the c	ause(s) and manner stated
P With		29b. Signature and title of certific	remera			29c. License r	13		4-1-	signed (Month,	
- •5		30. Name and address of person	who completed carries of the 2-1116	Jest, M) (Type, Pri	404 S	EATTEN	V BLV	Δ.	Essep.	M 2124
Sta Registr		31. Date filed (Month, Day, Year) APR 0 5		rar's Signature	ha	Ked					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Registrar . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Kenneth Mark Ballinger Physician/ 01 201 1 ear April 1:00 P.M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death

Baltimore County **Examiner** Towson Gilchrist Hospice Center If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number Sex 1 M 2 F 8. Date of Birth 7. Age (In vrs. last birthday) **Funeral** Months Days Hours March 16, 1970 Cincinnati, Chio 282-60-5055 41 Director Usual Residence of Decedent 28a-f show 10b County 10d. Inside City Limits 10a. State 10c. City. Town or Location with the Maryland Director notified 1 Tes 2 No Cockeysville Baltimore County Maryland 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō ms 23a or must be r Funeral United States 21030 301 Foxfire Place Apt.C items Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status rmed Forces? Black White etc Examin 1 Never Married 2 Married ö ģ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify White Specify: "natural" Completed 3 Widowed 4 Divorced Year or Dates. **1988-94** Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry c than " College (1-4 or 5+) Elementary/Seconday (0-12) Customer Service Call Center Representative 12 event, the Be 18. Mother's Name (First, Middle, Maiden Surname)

Janice Irene Lanter 17. Father's Name (First, Middle, Last) alth and Mental H

27 is marked of

traumatic ever ပ Howard Herman Ballinger, Jr. 19a. Informant's Name/Relationship (Type, Print) **wife** 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

oper 301 Foxfire Place Apt.C Cockeysville, MD. 21030 Katherine Rose(nee Moning)Ballinger Health Department of Health Important: If item 27 any injury or other to once. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) Date 1 Burial 2 Cremation 3 Removal from State Exars Frear Cateland Tuesday, 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland April 05,2011 Cremation Services, Inc. Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Peneriil Atternatives Funeral and Cremation Center, P.A. drin Lic.#M00677 Timonium, Maryland 21093-2215 2325 York Road 23a. Part 1/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 000 disease or condition MOUNTAIN Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, I day, leading to immediate cause. Enter Underlying Examine Days to for early consequence of: -transit Cause (Disease or iinjury that initiated events resulting in death) Last and Due to (or as a consequence of): burialattending physician for use as the buria Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Hospital or Attending Physician: The law requires that the death Month 4 Pregnant : Pregnant at time of death signed by the a d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown plnods 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to predical director, 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1- Natural work? injury 5 Pending 2 No n 24 hours after death. e Funeral Director: A pleted filled in by the fi Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated completed (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month Dav. Year 2 71040 5+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHI BALTIMAR CHARIBS SULTE 11105 KUMAR 61 N

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 4:30 AM Burkhamer Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 8370 Brookwood Road Millersville Anne Arundel 5. Social Security Number Sex 1 M 2 D F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) ct. 16,1953 Months Days Mary land **Director** Oct. 215-70-3052 Usual Residence of Decedent 'natural", or items 23a or 28a-f show dical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Millersville 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 8370 Brookwood Road U.S.A. 21108 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Š Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☐ Divorced White Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Machinist Paper Box Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Burkhamer Lena J. Freeman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health a Lena J. Blake (Mother) 8370 Brookwood Road Millersville, Marvland 21108 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State þ Department of Important: If any injury or 4 ☐ Donation 5 ☐ Other (Specify) 04/06/2011 Carmel U.M. Cem. Pasadena, Maryland 21. Signature of Furieral Service Licensee Name and Address of Facility cCully-Polyniak Funeral Home, P.A. 204 Mountain Road Pasadena, Maryland 23a. P 📶 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final lun Physician/ disease or condition resulting in death) Medical Due to (or as a conset Examiner Sequentially list conditions Examiner if any, leading to immediate cause Ent r Incorp.

Cause (Disease or iinjury Due to (or as a consequence of) use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Be Completed by Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Day Pregnant at time of death Month Year Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director; After this certificate h death? 1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 일 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation completed filled in by the □ Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 🗌 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my onlinon, death occurred at the time, date and place, and due to the cause(s) and manner stated Continues To the basis of examination and/or investigation, in my onlinon, death occurred at the time, date and place, and due to the cause(s) and manner stated Continues Practice and Total Continues Practice and Place and Total Continues Practice and T 290 License number 38 use of death (Item 23a) (Type, Print) 30. Name and address of person who complet 6 MD. 21061 DR. JAMES BRUJAMIN EN BURNIE. State 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Physician/ 8:25 Рм Bruce Lee Baker, Sr. March 2011 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** N/A Baltimore City Joseph Richey Hospice Center If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** April 11,1951 Maryland Months 1**XX**M 2 □ F 59 **Director** 212**-**58-4335 Usual Residence of Decedent f show 10d. Inside City Limits 10c. City, Town or Location aţ 10a. State 10b. County with the Maryland Director or 28a-f sh notified Dundalk 1 🗌 Yes 2 ី No Baltimore MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number P "natural", or items 23a or Funeral 2005 Bear Ridge Road Apt. 102 United States 21222 death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. δ 1 Never Married 2 Married 1 ☐ Yes 2 🗶 No If Yes, Give Baltimore, Maryland 21215-0036 permit. Page 1 and 2 should be filed within 72 hours after 1 Yes 2X No Specify. Completed 3 Widowed 4 Divorced Black Year or Dates event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Health Care and Mental Hygiene. is marked other than Elementary/Seconday (0-12) 12 Years College (1-4 or 5+) Provider <u>Nurse Assistant</u> Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Evelyn McDonald Edward Rodell Baker 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2005~Bear~Ridge~Road~Apt.~102~Dundalk.~MD19a. Informant's Name/Relationship (Type, Print) Dundalk, MD 21222 Mr. Bruce Lee Baker, Jr. (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 4/4/2011 Towson, Maryland illtop Service Corp 4 ☐ Donation, 5 ☐ Other (Specify) 21, Signatur of Juneral Service Licenses 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc 7922 Wise Ave. Dundalk. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Orset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): been signed by the attending physician and should be detached for use as the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Pregnant at time of death 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other, significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown After this certificate has been funeral director, page 2 shoul 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 No Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 2 🗌 No မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28c. Injury at 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certificate: work Natural 5 Pending 1 🗌 Yes 2 🗌 No Accident Investigation after death Director: / 6 Could not be determined in 24 hou. the Funeral Direc. Suicide 28f. Location (Street and Number or Rural Route Number, Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month. Day, Year) 29c. License number 30. Name and address of person who come eted cause of death (Item 23a) (Type, Print 32. Regist State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Frances M. Bocian April 2, Year 2011 Physician/ 2:05 PM Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner N/A Baltimore 1425 West 41st Street If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth Birthplace (State or Foreign Country) Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days 1 M 2 XX Director 214-18-3658 89 July 19, 1921 MD Usual Residence of Decedent 10d. Inside City Limits ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10c, City, Town or Location should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28a-f shov 10a. State 10b. County Director XX Yes 2 No MD N/A Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code by Funeral U.S.A. 21211 1425 West 41st Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 Yes 2 XXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: White 3 Widowed 4 □ Divorced Completed Year or Dates. 16b. Kind of Business Industry 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Walter Ridgely Mattie Belle Parks permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic e once. other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1835 Edgewood Avenue Balto, MD 21234 Stephen Bocian (Son) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 KBurial 2 Cremation 3 Removal from State Gardens of Faith Cemetery 4/6/11 Baltimore, MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burgee Henss Seitz Funeral Home, 3631 Falls Road Balto, MD 2121 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of): if any, leading to immediate cause Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) injury work? 1 ☐ Yes 2 ☐ No Natural Accident 5 Pending Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number D0052563 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Laven Blod. Lock Nainas 5601 J. 1 MD

DHMH 17 Rev 7/2009

Registrar

32. Registrar's Signature

11-02467 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. **Bradford Curtis Bacon** State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 1. Decedent's Name (First, Middle,Last) 2. Date of Death 3 Time of Death Physician/ Month Day March 31, 2011 0013 hrs Medical Examiner Bradford Curtis Bacon 4a. Facility Name (if not institution, give street end number) 4b. City, Town, or Location of Death 4c. County of Death 5900 Lafayette Avenue Riverdale Prince George's 5. Social Security Number 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Country) DE Min Months Davs Hours 222-42-3018 Director 41 Dec. 12, 1969 1 X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location Au 10a. State 1 Yes 2 X No 28a-f show MD Prince George's Brentwood other than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at once, permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 77 is marked other than "matural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once. Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 3824 37th Place 20722 Funeral 11 Marital Status 14 Race - American Indian Black 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married Armed Forces? White, etc. 2 X No Yes White 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: \$ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 Self Employed Artist 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Ann Marie Gland Be Charles Newcomb Bacon IV 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ၉ 2 145 Hale Street, Beverly, MA 01915 Charles Bacon IV - Father 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State Baltimore, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4-4-2011 Glen Burnie, MD Atlantic Crematory Donation 5 Other Specify: 21. Signature Funeral Service License 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227 athlia aun 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line Medica Death Multiple Injuries Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical attending physician a for use as the burial -AMENDED 23a, 27, 28a-f per me g915 5-4-11 vt X UNPENDED • Hospital or Attending Physician: The law requires that the death certificate be extensing the death.
24 hours after death.
• Funeral Director. After this certificate has been signed by the attending physicia reley filled in by the funeral director, page 2 should be detached for use as the buria reley filled in by the funeral director, page 2 should be detached for use as the buria Box 68760 IF FEMALE 23d. Date of delivery 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3 Ectopic pregnancy Year Month Day past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, P.O. ۵ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a, Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 No 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 🗸 Other: Scene 2 No 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day,Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? Certification: subject struck by a freight 1 Natural 5 Pending 1 Yes 2 X No fd 3-31-11 | fd 12:08pm train 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 5900 Lafayette Ave. Riverdale, Maryland 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 X Suicide 6 Could not be in 24 hous.

of the Funeral Decompletely fille found beside tracks face (Specify) down determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Sal 2 📝 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) March 31, 2011 O.C.M.E.

DHMH 17 Rev 1/2001 OCME 2006

State Registrar 111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

2. Registrar's Sign ture

Pamela E. Southall, MD

31. Date filed (Month, Day, Year)

11-02388 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Theodore T. Belfit State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 0757 hrs Theodore Thatcher Belfit **Medical Examiner** March 28, 2011 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Salisbury Wicomico 111 Circle Avenue If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Director 1979 fibrida 229-43-1435 1X M 2 F 7, 31 Usual Residence of Decedent 10d. Inside City Limits ij 10a State 10b. County 10c. City, Town or Location 1 Yes 2 No 28a-f show Pages I and 2 should be filed within 72 hours after death with the Maryland rost of Health and Mental Hygiene.

nnt: If item 27 is marked other than "natural", or items 23a or 28a-f sho Maryland Harford Bel Air 10e. Street and Number 10g, Citizen of What Country? 10f. Zip Code USA Building 203, Apt. I, Foxhall Dr. 21015 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 Never Married 2 Married 2 X No 1 Yes White 4 Divorced If Yes, Give Year 1 Yes 2X No specify: Specify: ≦ 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) pleted during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Arborist Tree Company Com 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Scott Curtis Belfit Victoria Joan Floyd Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Scott C. Belfit / Father P.O. Box 16, Gunpowder, Maryland 21010 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) injury or other 1 Burial 2 X Cremation 3 Removal from State Department of 4 Donation 5 Other Specify: Service Corp 04 - 05 - 11Towson, Maryland 22. Name and Address o acility McComas Funeral Home, P.A. 21. Signature of Funeral Service Licensee 23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Physician /Medical Death Hydrocodone and Alcohol Intoxication Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): attending physician and or use as the burial - transi The law requires that the death certificate be executed Physician/Medical AMENDED 23a,27,28a-f per me g914 4-22-11 vt X UNPENDED Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE: 23b. Was decedent pregnant in the 1 Live birth Year Month Day Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ₫ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of After this certificate has death? performed? ✓ Yes 2 No 1 Yes 2 No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifit completely filled in by the funeral director; 25. Was case referred to medical 26.Place of Death (Check only one) Division of Vital Be Hospital: 1 Inpatient 2 Other A Nursing Home 5 Residence 6 🗸 Other Scene ER/Outpatient 3 DOA 1 🗸 Yes 28a. Date of Injury 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 1 Yes 2 X No 5 Pending fd 3-28-11 fd 7:50am unknown 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Suicide 6 X Could not be (Specify) 4 Homicide stairwell Circle Ave. Salisbury, Md 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 뗭 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medic

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifier

Zabiullah Ali, M.D.

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registra s Signature

30. Name and address of person who completed cause of death (Item 23a)

29d. Date signed (Month, Day, Year)

March 29, 2011

29c. License number

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Bertha Blick 7: 06 AM 201 Dru Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Tate Hospice House Linthicum Heights Anne Arundel 5. Social Security Number 214-20-9262 If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Birthplace (State or Foreign Country) (Month, Day, 1 □ M 2XXF Months Days Hours Min. Director Dec. Usual Residence of Decedent should be filed within 72 hours and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show arked other than "natural", are items 25a or 28a-f show arked other than "must be notified at at a must be notified at a must be notified. 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Anne Arundel Glen Burnie 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 211 Wellham Avenue 21061 U.S.A. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No If Yes, Give Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 6 John T. Dodson Nellie E. Manuel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code Mrs Ernestine Stith/Daughter 1100 McHenry Drive Glen Burnie, Maryland 21061 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 7, 1 XBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Glen Haven Mem. 2011 Glen Burnie, MD 21. Signature of Funeral 22. Name and Address of Facility Singleton Funeral & Cremation ervice Deensee Services PA 1 2nd Ave. SW Glen Burnie MD 21061 K1220 Prit 1. Inter the discusse, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) DEMENTI Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Dav Year Pregnant at time of death 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed 2 No 3 ☐ Probably 4 ☐ Unknown 1 Tyes 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a. Was an Was an autopsy performed Yes To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other:
4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) (Specify) မ 1 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 3 Inpatient 2 Inpatient 2 Inpatient 3 Inpa 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred Natural injury 5 Pending Accident
Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion death, and the cause of the c 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person was completed cause of death (Item 23a) (Type, Print) Mohur

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

5

Box 68760

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Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 4:26 am **Physician** 2011 Wayne Benser Facilify Name (If not institution, give street and number) /Medical 4th City, Town, or Location of Death 4c. County of Death Examiner Himiye r 1 Year | If Under 24 Hrs. Age (In yrs. last birthday) Birthplace (State or Foreign Countryunk 8. Date of Birth (Month, Day, Year) 5. Social Security Number unk **Funeral** Hours Director Jan Usual Residence of Decedent permit, Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, its Madical Exercises must be notified at once. 10d. Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 Yes 2 □ No Baltimore MD Funeral Director 10g. Citizen of What Country? 10f. Zip Code 21223 10e Street and Number USA 2400 Wilkens Ave. 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status unk 1 Never Married 2 Married white 3altimore, Maryland 21215-0036 1 ☐ Yes 2X No ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation
(Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) unk Elementary/Secondary (0-12) unk 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) unk Be ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 900 W. Caton Ave; Baltimore, Maryland 21229 St. Agnes Hospital 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 📉 Other (Specify) in State Director 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Survice Licenses 655 W. Baltimore St; Baltimore, MD 21201 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Atherosclerotic Gnhasun **Physician** CardioVasculas disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner or Attending Physician: The law requires that the death certificate be executed the attending physician and ned for use as the burial-transi Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Vital Records, P.O. 9 Unknown cate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. δ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate has autonsv performed? 1 □ Yes 2 ☑ No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To After this funeral 28b. Time of Injury 27, Manner of Death 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death Director: the 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 50293 27 2011 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BACTIMENE

Registrar

DHMH 17 Rev 1/2001

State

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1	For Amend Item State Registrar	ms 28b, f per	aryland Den me,g914.0 Ce	14705/2611 Prtificate of D	eath Death	ientai Hyg R	eg. No.	10737
Г	Physicia	n/	1. Decedent's Name (First, Middle	e, Last)	LUTI	AIR		2. Date of Death		3. Time of Death
ž. š.	Medic Examin	_	4a. Facility Name (if not institution Seasons Hospic			4b. City, Town, or Randalls	Location of Death		4c. County of Death Baltimore	2
	Funeral Director		5. Social Security Number 220-56-2046	6. Sex 7. Age	(In yrs. last birthday) O Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birt	nplace (State or Foreign IntroMaryland
	8	l. h	Usual Residence of Decedent 10a. State 10b. County		10c. City, Town or L	ocation				10d. Inside City Limits
	Maryla 28a-f otifiec	Director	MD Balti	more	Halethor	pe				1 ☐ Yes 2 ☐XNo
	with the 23a or 2	Funeral D	10e. Street and Number 5553 Oregon	Avenue		10f. Zip Code 21227	1	1	10g. Citizen of What Co USA	untry?
980	72 hours after death with the Maryland n"natural", or items 23a or 28a-f show fledical Examiner must be notified at	β	11. Marital Status 1 ☐ Never Married 2 🖾 Mar 3 ☐ Widowed 4 ☐ Divorced	If Voc Civo A		Was Decedent of His If Yes, specify Cubar 1 Yes 2 No	spanic Origin? (Spen, Mexican, Puerto I Specify:	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White White Specify:	
21215-0036	F - 2	Completed		nt's Education est grade completed) College (1-4 or 5	(Give	edent's Usual Occupa e kind of work done d DO NOT use retired)	ation luring most of worki	ng	16b. Kind of Business	ndustry
21	led within 'Hygiene. Other thar ent, the M		12	1	T	echnician			Toshiba	
Maryland		To Be	17. Father's Name (First, Middle, Francis Lee				18. Mother's Name	,	Maiden Surname)	
lan	should land Me		19a. Informant's Name/Relations	hip (Type, Print)					City or Town, State, Zip	
	1 and 2 should by f Health and Men item 27 is marke other traumatic		Brenda Cutair- 20a, Method of Disposition	-Wife	20b. Place of Disc	osition (Name of			pe Maryland 20c. Location - City or	
Baltimore,	t. Page tment o tant: If ijury or		1 Burial 2 XCremation 4 Donation 5 Other	Specify)	Attantic	Crematory or other place Crematory			Glen Burnie	
Bai	permit. Pag Department Important: any injury o		L1. Si Full Service	NUN	ny 1	1328 Sulpl	nur Sprin	g Road A		nc. yland 21227
M _O	hysician/	S 0	23a. Part 1. Enter the disease, o shock, or heart failure. List Immediate Cause (Final disease or condition	r complications that caused only one cause on each line	₽.	nter the mode of dying		er respiratory arre	est,	Approximate Interval Between Onset and Death
	Medical Examiner		resulting in death)	Due to (or as	a consequence of):			sed/	" My	
	ted	Examiner	Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as	a consequence cry		MORKO		Ello,	
-	ate be executed ohysician and the burial-transit	al Exa	that initiated events resulting in death) Last	C. Due to (or as	a consequence of):		- KK	Wir	W.	
760	th Ch	ledical I		d				S X		
Box 687	Attending Physician: The law requires that the death certifics or death. sctor: After this certificate has been signed by the attending its partial director, page 2 should be detached for use as by the funeral director, page 2.	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 Live Birth 4 Pregnant a 9 Unknown	2 Fetal death 3	☐ Ectopic pregnand ☐ Other (specify)	Cy /		23d. Date of de Month	livery Day Year
ds, P.O.	requires that the de been signed by the should be detached		Part II. Other significant condit	ner significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause 1					274	
Records,	sician: The law rer certificate has be irector, page 2 shc	Completed by						1 🗌 Yes	prior to death?	topsy findings available completion of cause of
Vital	sician: The certificate lirector, pag	To Be	25. Was case referred to medica examiner? 1	Hospital:	ient 2 ☐ ER/Outpat	lothi	er:		lence 6 X other (Spec	pie
of \	ig Phys ter this neral di		27. Manner of Death	28a. Date of inju	ury 28b. Time	of 28c. Injury	y at	28d. Describe h	ow injury occurred	
ion	ttendir death. tor: Af	Certificate:	2 Accident Inves 3 Suicide 6 Could	tigation March 14	ury - At home, farm, s	own _M 1 🗆	Yes 2 No	,	and fall	ral Route Number.
Division	ital or Airs after al Directed in by	al Cer		building, et	c. (Specify) MANER	NURSING				ral Route Number, ilkens Ave.,
1)	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After thi completed filled in by the funeral	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of G S Nurve Fractioner To the	examination and/or inv	estigation, in my opinio	on, death occurred a	t the time, date a	nd place, and due to the	cause(s) and manner stated.
	To the Within Common	-	29b. Signature and title of cartific	o 1000	Man	29c. Licenso	e number 1587	2	29d. Date signed (Mont	h, Day, Year) 9, ZØ //
_			30. Name and address of person	who completed cause of the BCB	death (Item 23a) (Type	Print) AviAh	on Blo	ed Su	in Lon	21061
	Sta Registr		31. Date filed (Month, Day, Year) APR 0 5	2011 33: Registr	rar's Signature	arked	. 62		E)	

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiens | | | State
Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Day Year PM Physician/ PMAN march ME 0 Medical 4c. County of Death 4a. Facility Name (if not institution, give street an Examiner enve 8. Date of Birth g. Birthplace (State or Foreign Number **Funeral** (Month, Day, Year) Country) Months 1 M 2 F Director 10 21 MD permit. Page 1 and 2 should be filed within 72 hours area www.
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show important items 25a or 28a-f show 10d. Inside City Limits 10c. City, Town or Location 10b. County Director 1 X Yes Z INO salti more 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21215 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Year or Dates. δ 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 lack Specify: **3**€ Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) State of Maryland <u>Administrator Booking</u> 2yrs 2th grade Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 Mary Faulkner Roosevelt Pitt Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5309 Fairlawn Ave, Baltimore, Md 21215 Tyrone Chapman-Husband Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/7/2011 Woodlawn, Md Woodlawn 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Ave, 21215 Baltimore, 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear tailure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 as been signed by the attending should be detached for use as IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death 1 Yes 2 g Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 2 No 3 Probably 4 🖲 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has be completed filled in by the funeral director, page 2 sl autop perfor 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ျ 1 Yes 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 🗆 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 507 erson who completed cause of death (Item 23a) (Type, Print) PLACE 345 ACUM MO (Month 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend Item 9 per fh 9914 4-6-11 vt. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Louis В. Cooper 03 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Center Baltimore Franklin Sa 5. Social Security Number Rosedale nare 7. Age (In yrs. last birthday, If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕱 M 2 🗆 F Months Days Hours Min. 06-18-86 218-15-5111 Director 24 MD. Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director VA Prince WilliamWoodbridge 1 Yes XX No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 22193-2156 3800 Fortuna Court USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Armed Forces? Black, White, etc. African 1 Never Married 2 Married þ ピューレのセミン Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X ☐ No Specify: Specify: American 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ementary/Seconday (0-12) College (1-4 or 5+) Disabled 10th Grade unemployed NA 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Louis Cooper, Sr. Sylvia С. Perkins 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Aisha Henton-Friend Capella Court Rosedale, MD Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) ing Mem. Pk. 1XXBurial 2 Cremation 3 Removal from State King 04-02-11 Randallstown, MD 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Street Baltimore, MD 21217 Gilmore Ν. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Ph sician/ Cerebra Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence oi). Exami Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death signed by the a Yes 2 No Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Completed 1 Tes 2 No 3 Probably 4 Unknown certificate has been si irector, page 2 should? 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🕱 No 1 Tyes 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital Other: 은 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending injury work 1 🗆 Yes 2 🗆 No Accident Investigation the 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Funeral D Medical 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. within 24 ho

To the Fune (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one 3-G Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) 30. Name and address, of person who completed cause of death (Item 23a) (Type, Print) 9000 Frank Carrie ware Drive Bultimore MD. 31. Date filed (Month, Day, Year) 32. Registror's Signature State Registrar

DHMH 17 Rev 7/2009

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Donald 03 29 2011 10:05p^M Carter /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Future Care Nursing Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months 1**X** M 2□ F 74 25 **Director** 218-34-2225 09 PA Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits ns 23a or 28a-f show must be notifled at 1XYes 2 No Director MD NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3402 Ripple Road 21244 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) ?7 Is marked other than "natural", or items traumatic event, the Me It al Examiner my 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 ☐ Yes 2 [X] No If Yes, Give Year or Dates: X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black by 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 73 h and Mental Hygiene.
7 Is marked other than "n. Elementary/Secondary (0-12) College (1-4or 5+) 12th grade Mechanic <u>Western Auto</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roosevelt Carter <u>Judith Carter</u> 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1 and 2 s Health an Cecelia Walston-caregiver 3402 Ripple Road, Baltimore, Md 21244 permit. Pages 1 and Department of Healt Important: If item 2: any Injury or other i 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【A Cremation 3 ☐ Removal from State On-Site 4/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Baltimore, Md 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave, Baltimore, Md 21215 23a. Part . Enter the it sease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shows, or hear "silure. List only one cause on each line." Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of) Examiner 042 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ned by the attending physician and detached for use as the burial-transit Due to (or as a consequence of) P.O. Box 68760, Physician/Medical 23c. If yes, outcome pf pregnancy 1□Live birth 2□Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 5 ☐ Other (specify) 4☐Pregnant at time of death 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division or Vital Records, 9 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 1☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 TYes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manny of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: (Month, Ďay Year) Injury 5 Pending To the Hospital or Attendil within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 1 □ Yes 2 □ No 2 Accident 6 Could not be determined 3 ☐ Suicide Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 🖫 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3-30-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

DHMH 17 Rev 1/2001

State Registrar DAKSHAN

31. Date filed (Month, Day, Year)
APR 0 5 2011

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Mar

SALUIA

32. Registrar's Signature

6821 Reisterstown 140

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day} 2011 Physician/ March 31 4:15 AM Norman Lee Collison Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cockeysville

| If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | Jan. 6, 1925 Baltimore MD Masonic Homes 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Baltimore, MD Director 215-12-4661 86 Usual Residence of Decedent your i 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location "natural", or items 23a or 28a-f sho filed within 72 hours after death with the Maryland Director 1 Yes 2 No Cockeysville Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21030 300 International Circle Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: White Specify: 3 Widowed 4 Divorced Completed . Page 1 and 2 should be filed within 72 hour: iment of Health and Mental Hygiene. tant: If item 27 is marked other than "natu jury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Tool & Die Maker Manufacturing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mary Elizabeth Blucher Norman Vanest Collison 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Daughter 16110 Sherwin Ct. New Freedom, PA 17349 Lesleigh Collison Kelly 20b. Place of Disposition (Name of cemetery, crematory or other place)
St. Michael s 20a. Method of Disposition 20c. Location - City or Town, State artment of ortant: If it injury or o April 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Perry Hall, MD Cemetery per nit. I Der artm Imr orta any inju once. Signature of Funeral Service/Licensee 22. Name and Address of Facility Lemmon Funeral Home of Dulaney Valley, 10 W. Padoni<u>a Road Timonium, MD 21093</u> Bran W. Clary 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause in each line. Approximate Interval Between Onset and Death Immediate (Final Physician/ disease or condition resulting in death) pera - MRSA Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): and -transit or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): burialattending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live Birth 2 ☐ Fetal deal 4 ☐ Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Yes 2 No as been signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Endoradetis, manujetis, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? DUT, UN responsine 24a. Was an Jas autopsy ir this certificate hat eral director, page 2 performed Yes 2 YN 1 ☐ Yes 2 💆 No 25. Was case referred to medical examiner? B B 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No မ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural work? 1 ☐ Yes 2 ☐ No 5 Pending within 24 hours after death.

To the Funeral Director: After completed filled in by the fun 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours at To the Funeral D Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) clotto, ms. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) rul 2122 3508 Bank RUBON LIBERTO IND

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 0 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Physician/ John Cannon Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** University of Maryland Social Security Number If Under 1 Year If Under 24 Hrs. **Funeral** 6. Sex 7. Age (In yrs. last birthday) Days Hours 1 □XM 2 □ F 75 **Director** 215-32-8916 Usual Residence of Decedent 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. Tatt. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10c. City, Town or Location event, the Medical Examiner must be notified at Director Anne Arundel Brooklyn Park 10e. Street and Number 10f. Zip Code Funeral 21225 613 Luther Street Be Completed by 1 Never Married 2 XMarried ARMY Baltimore, Maryland 21215-0036 1 ☐ Yes 2X☐ No Specify: 3 🗆 Widowed 4 🗆 Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed)

College (1-4 or 5+)

1 ☐ Yes 2 🛣 No 10g. Citizen of What Country? United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Manager Grocery 18. Mother's Name (First, Middle, Maiden Surname) Della May Unglesbee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

613 Luther Street, Brooklyn Park, MD 21225

4-5-2011

Date

22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd., Arbutus, MD 21227

2. Date of Death

8. Date of Birth Sep • 21

2011

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

Maryland

4c. County of Death

N/A

Year)1935

Month

permit. Page 1 a
Department of H
Important; If ite
any injury or ot
once,

Examiner

Physician/Medical

Completed by

Certificate: To Be

Medical

ပ

Physician/ Medical Examiner

the Hospital or Attending Physician: The law requires that the death certificate be executed

within 24 hours after death.

To the Funeral Director: After this certifical completed filled in by the funeral director,

P.O. Box 68760

Division of Vital Records,

other traumatic

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last

20a. Method of Disposition

Elementary/Seconday (0-12)

17. Father's Name (First, Middle, Last)

John Paul Cannon,

19a. Informant's Name/Relationship (Type, Print)

A ☐ Donation 5 ☐ Other (Specify) Signature of Faheral Service Li

Peggy M. Cannon - Wife

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State

	r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line.
Immediate Cause (Final disease or condition resulting in death)	a. Sees Sees Cardinger C
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a consequence of):
Cause (Disease or iinjury that initiated events resulting in death) Last	c. Due to (or as a consequence of):

23c. If yes, outcome of pregnancy
4 Pregnant at time of death

ıth	3 Ectopic pregnancy 5 Other (specify)

23d. Date of de	livery
Month	Da

20c. Location - City or Town, State

Crownsville, MD

IF FEMALE: 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 9 Unknown

uting to death but not resulting in the underlying cause given in Part

2 ER/Outpatient 3 D

28b. Time of injury

20b. Place of Disposition (Name of

MD Wereran's Cemetery

236. Did tobact	o us	e com
1 🗆 Yes	2 [] No
24a. Was an		24b.

performed'

No	3 Probably	4 U nknown
24b.		indings available tion of cause of

25. Was case referred to medical examiner?
1 Yes 2 M No

Part II. Other significant conditions contrib

Hos	spital:			/		_
		1	Y	In	patier	ıt
	28a.	D	ate	of	injury	
- 4		(N	1on	th,	Day,	Yε

28e. Place of Injury -building, etc. (Sp

MD

OA		4 Nursing H	ome	5 Residence	6 U Other
	Injury at work? 1 \(\sime\) Yes	s 2 🗆 No	28d.	Describe how inj	ury occurred

Other

26. Place of Death (Check only one)

	1 ☐ Yes 2 🗹	No 1 ☐ Yes	2 🗌 No
con	ly one)		
me	5 Residence	6 ☐ Other (Specify	1)

death?

27.	Manner of Death
	1 Matural
	2 Accident
	3 🗌 Suicide
	4 Homicide

5	Pending	
	Investigati	10
6	Could not	b

			М	1	
At ho	farm,	street,	facto	ry, offi	се

f. Location (Stre	et and Numb	er or Rural Ro	oute Numb
	f. Location (Stre	f. Location (Street and Numb	f. Location (Street and Number or Rural Ro City or Town, State)

(Check 2 Medical Examiner: On the basis of examination and/or investigation	1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)								

1699900522

29d.	Date	signed	(Month,	Day,	Year)
Λ	_	A.			

ANEJAN

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 22 Greens

State Registrar 31. Date filed (Month, Day, Year, APR 0 5 20

32. Registrar's Signature

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ ^{Day} 2011 Month Albert Carlsten Carl 4:05 P M Medical April 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Towson **Examiner** 4c. County of Death Blakehurst Baltimore 5. Social Security Number 6. Sex 1 M 2 D F 8. Date of Birth (Month, Day, Yea 9/26/1917 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Months Days Min. 93 Hours 331-12-6928 Director Illinois Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits Funeral Director Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 9 10f. Zip Code 10g. Citizen of What Country? 23a 21204 1055 W. Joppa Road #444 U.S.A. 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces ö ò 1 Never Married 2 Married Black, White, etc. 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: "natural", 3 X Widowed 4 Divorced Completed white Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me any injury or other traumatic event, Elementary/Seconday (0-12) College (1-4 or 5+) Engineering Electrician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Albert E. Carlsten Carrie Apland 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lebanon, New Jersey 08833 15 Chalfonte Dr. Lynn Douglass / Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 X Cremation 3 ☐ Removal from State 4/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland HIlltop Serv. Corp. 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fineral/Service Licensee Towson, Maryland 21204 1050 York Road art 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ebili disease or condition Medical resulting in death) Due to (or as a consequence possible Bladder concer Examiner months Secondary 70 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to for as a consequence on burial-tran Due to (or as a consequence of) resulting in death) Last certificate be Box 68760 attending pl IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery the Hospital or Attending Physician: The law requires that the death thin 24 hours after death. Thin 24 hours after death.

the Funeral Director: After this certificate has been signed by the attention of the thin the funeral Director. in the past 12 months? Ectopic pregnancy Other (specify) Month Dav Year 1 Yes 2 9 Unknown Pregnant at time of death 2 No ed by the a detached f 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. After this certificate has been signed funeral director, page 2 should be de 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed death? 2 No 2/ 25. Was case referred to medical examiner?

1 Yes 2 No Be 26. Place of Death (Check only one) Buskehus?

4 Nursing Home 5 Residence 6 Other (Specify) Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 1 ☐ Yes 2 ☐ No Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier only one) 3 🗌 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of 30. Name and address of person who completed cause of ceath (Item 23a) (Type, Print) 31. Date filed (Month, Day, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

oseph Ch	ambe		Si 1- For State Registrar	ate of Maryla	•		ent of late of l		nd l	Mental	Нус	jiene	Reg. No	20		10744	
Ph Jedical E	ysici xami	an/	Decedent's Name (First, Midd Joseph Cham	· ·								2. Date of Death Month Day Year March 20, 2011 3. Time of Death 0248 hrs					
			4a. Facility Name (if not institution 14 D Crescent Road		mber)			. City, Town,		cation of D		WIEI CIT Z	4	c. County o			
Fui	neral		5. Social Security Numberunk	6. Sex	7. Age (In yrs.	last birth		If Under 1 Ye	ear I	f Under 24	_	8. Date of			9. Birt	hplace (State or	
Dire	ector			1 M 2 F		56	Yrs.	Months Da	ays	Hours	Min.	Dec 2	23,	1954	Foreig Cou	untry)	
	any		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town o	or Location)						10d. Inside City Limits			
land	28a-f show i at once.	ģ		e George's	(Gree	nbe1t									1 Yes 2 No	
he Mar	23a or 28a-f sho notified at once	Director	10e. Street and Number 14 D Cresce:	nt Road				10f. Zip Code		0770			10g. Ci	tizen of Wh		ntry?	
h with t	ms 23a		11. Marital Status	unk 12. Was Dece				Decedent of H	lispan	nic Origin?			No-		Americ	can Indian, Black,	
ter deat	, or ite	Funera	1 Never Married 2 M 3 Widowed 4 Div	arried 1 Yes Yorced If Yes, Give Year	2 No 1	ınk		es 2X N				Jan, 100.7		Specify:		te	
nours af	(xamin	ed by	15. Decedent's Education (Spe	or Dates: cify only highest grad	e completed)	16a. D	ecedent's	Usual Occup	ation	(Give kind	of wor	k done ur	1k 16b.	Kind of Bus			
36 thin 72	than "	Completed	Elementary/Secondary (0-12) unk	College (1- unk	4 or 5+)							•					
MD 21215-0036 12 should be filed within 72 hours after death with the Maryland th and Menral Hoviene	t: If item 27 is marked other than "no other traumatic event, the Medical Es		17. Father's Name (First, Middle					unk	18.1	Mother's N	ame (F	irst, Middle	e, Maider	n Surname)		unk	
ore, MD 21215-(ies I and 2 should be filed v	marke ic even	To Be	19a. Informant's Name/Relations	hip (Type, Print)		19b.	Mailing A	ddress (Str	eet an	id Number	or Rur	al Route N	umber, (City or Town	, State,	Zip Code)	
M 2 sh	If item 27 is her traumati		O.C.M.E. 20a. Method of Disposition		1 20h			. Balt				et Ba				21201 Town, State	
nore	t: If it other t		1 Burial 2 Cremation	Arr	m State		ry or othe		CITICA	21,5,	-	,a.c	200.	Location	Oity Oi	Town, Glace	
Baltimore, permit. Pages la Department of He	Important: If item injury or other traur	ŀ	Donation 5 X Other Sp. 21. Signature of Funeral Service Ronal C.	License I A a Le	<u>te </u> D∡recto	r	22.SNar	ne and Addre	are d	Faffy B	oar	d 655	W.	Balti	mor	e Street	
Physi		_	23a. Part I. Enter the disease, or	complications that ca	used the death	. Do not	Ba enter the	1timor	e, g, suc	MD h as cardi	2120 ac or re	01 espiratory a	arrest, sh	lock, or hea	rt	Approximate Interval	
/Med	dical		failure. List only one cause Immediate Cause (Final disease	on each line. Ath	erosc1											Between Onset and Death	
			or condition resulting in death)	Due to (or as a b.	consequence o	of):											
		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence o	of):											
pa	nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence o	of):				-							
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8760 ificate b	attending physician and for use as the burial - transi	n/Me	IF FEMALE: 23b. Was decedent pregnant in th		utcome of preg	nancy 2	Fetal	death 3	ПЕ	Ectopic pre	egnancy	,	23	Bd. Date of o		ay Year	
Box 6876(attendir for use a	sician/Me	past 12 months? 1 Yes 2 No 9 Uni	_	nt at time of de			(Specify)									
at the de	by the	y Phys	Part II. Other significant condit			esulting	in the unc	lerlying cause	giver	n in Part I.						he cause of death?	
IS, P.O	ge ag	ted by									_	1 Y				ably 4 Unknown	
COTC e law re	e has been s	Completed									_	aut per	opsy form <u>ed</u> ?	pr de	ior to co eath?	ompletion of cause of	
al Re ⊪	his certificate director, page	0	25. Was case referred to medica	i				26.Plac		Death (Che	eck only	1 Yes	21	No 1	Yes	2 No	
f Vit	er this c ral dire	To B	examiner? 1 Yes 2 No 27. Manner of Death	Hospital: 1 In	patient 2		patient :			er ₄ Nu Work?		d Describ		ence 6		Scene	
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Division of Vital Records, tal or Attending Physician: The law require is after death,	filled in by the	Certification:	3 Suicide 6 Coul	d not be rmined (Specify)	of Injury - At he	ome, far	m, street,	factory, office	buildi	ing, etc.	28	f. Location or Town		and Number	or Rur	al Route Number, City	
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			Manysia	the Upril				0.0	.М.Е				Ма	rch 20, 2	011		
		ļ	 Name and address of person Margarita Korell MD. 	who completed cause Assistant Med	•		111 Per	n Street, i	 Baltir	more, M	D 21:	201	-				
	St Regist		31. Date filed (Month, Day, Year)	32. Reg	istrar's Signatu	ıre	4.1			-							

ORIGINAL

11-02126 Fred Coger, Jr Please Type or Print in Black Indelible Ink. Ensure All Copies, Are Legible. JH State of Maryland / Department of Fleath and Wentak Hypienes (2011)

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Physicia Medical Examin	_	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year March 18, 2011 3. Time of Death 1405 hrs
modioa: Examin		Fred Coger Jr March 18, 2011 1405 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death
,		7521 Blair Road Apt # 2 Silver Spring Montgomery
Funeral Director		5. Social Security Numberunk 6. Sex 12-66-2943 7. Age (In yrs. last birthday) 70 yrs. The security Number 1 Year 1 (In Under 1 Year 1 (In Under 2 4 Hrs. 1 Nonths 1 N
any	- 1	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits
E	٦	MD Montgomery Silver Springs 1 Tyes 2 XNo
e Marylaur 28a-f	Director	10e. Street and Number 7521 Blair Road #2 10f. Zip Code 10g. Citizen of What Country? USA
	Funeral D	11. Marital Status 1 Never Married 12. Was Decedent Ever in U.S. Armed Forces? Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Black
after d	ð F	3 Widowed 4 Divorced If Yes, Give Year or Dates: 1 Yes 2 No specify: Specify: White
hours natur	ᅙ	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work don unit during most of working life. DO NOT use retired) 16b. Kind of Business/Industry during most of working life. DO NOT use retired)
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2121 2121 Duld be fi Mental marked ic event,	å	Fred Coger , SR. Cynthia Boyd 19a Informant's Name/Polationship (Funa Point) 19b Mailing Address: (Street and Number of Purel Bayde Number City or Farm State 7 in Code)
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Baltimore, permit. Pages ! at Department of Hec Important: If ite		21. Signature and Address of Facility Port Apart Apart Apart Port Apart
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Examiner	-	or condition resulting in death) Due to (or as a consequence of):
	-	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated
uted id ansit	<u> </u>	events resulting in death) Last Due to (or as a consequence of): d.
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Box 687 e death certific the attending p	Ciar	past 12 months? 4 Pregnant at time of death 5 Other (Specify)
he deat	Physician/	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?
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IVISION or Attendather death Director:	icati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f, Location (Street and Number or Rural Route Number, City
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To with	ĕŀ	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year)
		March 19, 2011
	1	30. Name and address of person who completed cause of death (Item 23a) Maggarita March MD Assistant Madical Examinar 111 Penn Street Raltimore MD 21201
Sta	te.	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31 Date filed (Month, Day, Year) 32 Registrar's Signature
Registr		APR 0 5 2011 June 1. Sales
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State of Maryland / Department of Health and Mental Hygiene

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12		30. Name and address Patricia Aron					dical Ex		111	Penn St	treet, E	Baltimor	e, MD 212	201			
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ AMPBELL Month MAZCH NOWOTENSKI AROLF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Columbia Howard **Howard County General Hospital** If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 1 M 2 XF (Month, Day, Year) Nov 23, 1944 Country) 046-34-3599 66 Director Usual Residence of Decedent or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or items 23a or 28a-f sho important: If tiem 27 is marked other than "natural", or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD **Ellicott City** Howard 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3618 Windfall Terrace 21042 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Systems Analyst SSA Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Carroll John Nowotenski Helen Lpnicki 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3618 Windfall Terrace Ellicott City, MD 21042 Arthur B. Campbell husband 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Apr 01, 2011 Marriottsville, Maryland Crest Lawn Memorial Gardens 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Slack Funeral Home, P.A.
3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart Milure. List only one cause on each line Immediate Cause (Final disease or condition METASTATIC Physician/ ENDONE TRIAL Medical resulting in death) Due to (or as a consequence of): Examiner GRAM Secure fieldy list conditions if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury that initiated events resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 morths?
1 Yes 2 No
9 Unknown Month Dav Year Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ 28a. Date of injury 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Anatural 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Hospital Medical 🖟 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier npleted 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of certifier Kuttoch no 30. Name and address of person who completed cause of peath (Item 23a) (Type, Print) SNITE 35 300 mmory B.ATIMORE 31. Date filed (Month, Day, Year) -32. Registrar's Signature State Registrar

Box 68760

Records,

of Vital

Division

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Alfred Lee Disney 2011 10:17 a^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Frederick 2728 Bill Dorsey Blvd. Adamstown Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🖾 M 2 🗆 F (Month, Day, Year) March 22,1922 Months Days Hours Min. Country) **Director** 578-24-6512 89 MD Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a. State with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No Frederick Adamstown MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a USA 21710 2728 Bill Dorsey Blvd. hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No n "natural", or iten ledical Examiner n Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14. Race - American Indian, Black White etc. 1 Never Married 2 Married by Maryland 21215-0036 1 ☐ Yes 2 ☒ No Specify: white Completed 3 Widowed 4 Divorced Year or Dates the Medical Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Automobile Mechanic 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) pe permit. Page 1 and 2 should be Department of Health and Ment Important: If item 27 is marke any injury or other traumatic once. Belle Esther Coar Wilton E. Disney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Shirley Marie Disney/ Wife</u> 2728 Bill Dorsey Blvd., Adamstown, MD 21710 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State April 3 2011 West Arundel Crem. 4 Donation 5 Other (Specify) Odenton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Donaldson Funeral Home, P.A. KeinStele M01053 313 Talbott Ave., Laurel, MD 20707 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Medical resulting in death) Due to (or as a c n) equence of Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): attending physician Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) Pregnant at time of death sbeen signed by the should be detached a ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nown has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performę page 2 this certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 X No Hospital Other: 1 🗌 Yes 욘 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After injury Natural 5 Pending s after death. Investigation Accident filled in by the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 24 hours a Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b, Signature and tive of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death SOAM Month **Physician** Lynch Griffin Dewald Jr. 2011 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Rosedale Baltimore FRANKLIN SQUARE HOSPITAL CENTER If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Social Security Number 9. Birthplace (State or Foreign 7. Age (In yrs. last birthdav) 6. Sex **Funeral** Months 1⊠M 2□ F 85 214 20 4411 Director Maryland May 25, 1925 Usual Residence of Decedent show 10a, State 10b. County 10c. City. Town or Location 10d. Inside City Limits 7 is marked other than "natural", or items 23a or 28a-f shov traumatic event, the Modical Examinat munt to modified at 1 ☐ Yes 2 ☑ No Director Maryland Baltimore Middle River with the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 55 Longeron Drive 21220 USA death 1 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 [25/es 2 ☐ No 14. Race - American Indian. 72 hours after 1 ☐ Never Married 2 ☐ Married Maryland 21215-0036 1 ☐ Yes 2 📉 No Specify. 2 If Yes, Give 1946/85 Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 12 should be filed within 7: h and Mental Hygiene.
7 is marked other than "n Elementary/Secondary (0-12) College (1-4or 5+) 10 Mechanic Aviation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Lynch Griffin Dewald Sr. Cora Horn 19a. Informant's Name/Relationship (Type. Print) 19b. Malling Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other trainsnee. Douglas Dewald (Son) 55 Longeron Dr. Baltimore, Maryland 21220 altimore, 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages 1 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory Inc. 4/5/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility W Bruzdzinski Funeral Home P.A. DW 1407 Old Eastern Avenue Essex, Maryland 21221 23a (a) t1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Preumonia 2 Weeks disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Usease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine law requires that the death certificate be executed sician and burial-trans Due to (or as a consequence of): P.O. Box 68760, attending physician for use as the burial Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 □ Yes 2 □ No Month Year 5 Other (specify) signed by the a d be detached f 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 2 icate has been si 1 res 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificate 2 No Division of Vital 1 □ Yes 2 1 No 1 Yes Physician: director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 ₹¶o 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To funeral To the Hospital or Attending Pl within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? After 1 Natural 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical (Check only one) and manner stated.

State Registrar

31. Date filed (Month, Day, Year) APR 0 5 2011

ND.

29b. Signature and title of certifier

Majid Cina

Franklin Square

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

9000

Drive,

29c. License number D63054

Baltimore, MO

29d. Date signed (Month, Day, Year)

April 4, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02423 State of Maryland / Department of Health and Mental Hygiene Gregory Davenport Certificate of Death 1- For State Reg. No Time of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ 0845 hrs March 29, 2011 Davenport Medical Examiner Gregory 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Baltimore** 1026 Edmondson Avenue 9. Birthplace (State or 8. Date of Birth(MM/DD/YYYY If Under 24Hrs. If Under 1 Year 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Hours Days Min unk. Country) MD 05-11-83 27 Director 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1XXYes 2 No f show Baltimore death with the Maryland 10g. Citizen of What Country? Directo 10f. Zip Code or items 23a or 28a-f must be notified at or 10e. Street and Number USA 21223 1026 Edmondson Avenue 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-Was Decedent Ever in U.S. Funeral 11. Marital Status White, etc. African If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces? 1 X Never Married 2 Married Yes specify: American 1 Yes 2 No specify: If Yes, Give Year I Hygiene. ed other than "natural", o t, the Medical Examiner n 3 Widowed 4 Divorced Pages 1 and 2 should be filed within 72 hours after ģ 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Home Improvement Laborer Baltimore, MD 21215-0036 Compl NA9th Grade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Donna N. Davenport Be Walter M. Davenport of Health and Mental 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) ဥ 1026 Edmondson Avenue Baltimore, MD 21223 Donna N. Thompson-Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, 20a. Method of Disposition crematory or other place) 1 Burial 2 Cremation 3 Removal from State 04-05-11 Arbutus, MD Arbutus Mem. Pk. permit. Page:
Department o
Important: 4 Donation 5 Other Specify. Wylie Funeral Home P.A. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Street Baltimore, MD 21217 nes 638 N. Gilmor Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Retween Onset and Physician failure. List only one cause on each line Death Wedical a. Multiple Gunshot Wounds Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or es a consequence of): Sequentially list conditions, Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): Exa events resulting in death) Last The law requires that the death certificate be executed and Physician/Medical AMENDED UNPENDED attending physician or use as the burial -23d. Date of delivery Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE Year Day Month Fetal death 3 Ectopic pregnancy 23b. Was decedent pregnant in the Live birth past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 1 Yes 2 No 3 Probably 4 Unknown ğ 24b. Were autopsy findings available Completed 24a Was an prior to completion of cause of autopsy performed death? has 2 No 1 ✓ Yes 2 No 1 🗸 Yes certificate l' ector, page 26 Place of Death (Check only one) 25 Was case referred to medical Be Other Nursing Home 5 Residence 6 Other: Scene examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA this dire 2 No 1 Yes 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) Mar 29, 2011 28b Time of Injury 8c. Injury at Work After 27. Manner of Death Subject shot 0839 hrs 1 Yes 2 ✔ No 1 Natural 5 Pending 28f. Location (Street and Number or Rural Route Number, City 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc or Town, State) 1026 Edmondson Avenue, Baltimore, MD 3 Suicide 6 Could not be

or Attending Physician: Division To the Hospital or Attendin within 24 hours after death.

To the Funeral Director: A completely filled in by the fu

(Specify) Rowhouse Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number **OCME** March 30, 2011

ed cause of death (Item 28a) 30. Name and address of person who complet

111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner

O.C.M.E.

31. Date filed (Month, Day, Year) State

29b. Signature and title of certifier

Theodore M. King, Jr., MD.

4 V Homicide

29a. Certifier 1

Medical

32. Registrar's Signature

alle

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 3 Physician/ 5/3 M Dutton Bernice Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITA Saltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 □ M 2 🕱 F 07/13/1925 MD Director 219-18-8333 Usual Residence of Decedent 23a or 28a-f shov 10b. County 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location Director MD BALTIMORE 1X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral USA 21217 2813 PARKWOOD AVENUE Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black. White, etc 1 Never Married 2 Married Specify: BLACK 1 ☐ Yes 2 X No Specify: 3 XWidowed 4 Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **EDUCATION** TEACHER Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ျ DOROTHY MAYS THOMPSON LEROY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2813 PARKWOOD AVENUE, BALTO., MD 21217 KIRK S. DUTTON, SR/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 04/11/2011 OWINGS MILLS, MD GARRISON FOR. VET 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility JAMES A. MORTON & SONS F. H., INC ames q. 1701 LAURENS ST., BALTO., MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury en phea the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (1r as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 menths?

1 Yes 2 No
9 Unknown Month Day Year 9 Unknown signed by t. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Heart failure, cordingopains 2 No 3 Probably 4 Unknown Completed 1 Yes Abrillation, sarcoidosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 X No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) director examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Nnpatient 2 - ER/Outpatient 3 - DOA မ After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending work? 1 ☐ Yes 2 ☐ No Accident Suicide Investigation Director 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours aft

To the Funeral Di

completed filled in Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 0066810 APRIL

Registrar
DHMH 17 Rev 7/2009

State

CWM

SINAL

HOSPITAL

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

WEINTRAUB

SHARON

0 5 2011

31. Date filed (Month, Day, Year)

			For State Registrar	State of M	aryland		irtment of t tificate of l		a Mental Hy	/gien Reg. N			
	Physicia Medic		1. Decedent's Name (First, Middle, La:	DAESC.	ANE	R			2. Date of De Month April	eath D	20 _{Year}	3. Time of Death 1:30 A M	
In.	Examir		4a. Facility Name (if not institution, give street and number) Presbyterian Home of Maryland				4b. City, Town, or Location of Death Towson			1	4c. County of Death Baltimore		
	Funeral Director									9. Birthi Coun Mich	place (State or Foreign try) i gan		
Baltimore, Maryland 21215-0036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	irector					r, Town or Location SON				10d. Inside City Limits 1 ☐ Yes 2 🄀 No		
		Funeral Director	10e. Street and Number 1106 Concordia Di	7	Decedent Ever in U.S. 13. \		10f. Zip Code 21286		O (Consider Veneral No.	10g. Citizen of What C		·	
		ed by Fu	11. Marital Status 1 ☐ Never Married 2 ☐ Married 3 ☐ XWidowed 4 ☐ Divorced	Armed Forces? 1 Yes 2 K Yon Give		- 1	/as Decedent of Hispanic Origin? (Specify Yes Yes, specify Cuban, Mexican, Puerto Rican, € ☐ Yes 2 No Specify:		r (Specify fes or No Jerto Rican, etc.)	Specific		ean Indian, etc. ite	
		Completed by	15. Decedent's E (Specify only highest gr Elementary/Seconday (0-12)	15. Decedent's Education (Specify only highest grade completed) mentary/Seconday (0-12) College (1-4 or 5+		16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Technician			working	16b. Kind of Business Industry Medical			
		To Be	17. Father's Name (First, Middle, Last) Lawrence Johnson						Name (First, Middle Laidlaw	rst, Middle, Maiden Surname) aW			
			9a. Informant's Name/Relationship (Type, Print) cott Daeschner / Son			•			e Towso	son, Maryland 21204			
		i i	1 Burial 2 X Cremation 3 Removal from State				ace of Disposition (Name of metery, crematory or other place) 1 top Serv. Corp. 22. Name and Address of Facility Puck Top			20c. Location - City or Town, State Towson, Maryland			
Ba			Mules	Mer		10	050 York	Road			uneral H land 2120	ome, Inc. 4	
	Physician/ Medical Examiner	her	shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of):							Approximate Interval Between Onset and Death			
260 779	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	ted by Physician/Medical Examiner	cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	c									
Box 68									23d. Date of deliver Month	23d. Date of delivery Month Day Year			
ds, P.O.										_			
Recor		Completed by							24a. Was auto perf 1 🗆 Yes	opsy ormed?	prior to co death?	psy findings available mpletion of cause of	
Division of Vital Records,		e: To Be	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify))			
		Certificate:	1 Autural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not b 4 Homicide determined	e 28e. Place of Inju	(Month, Day, Year) injury 28e. Place of Injury - At home, farm, building, etc. (Specify)		M 1		28f. Location (Street a City or Town, Stat		and Number or Rural Route Number, ate)		
		Medical	(Check 2 Medical Examonly one) 3 Certifying Nur	sician: To the best of ner: On the basis of e se Practioner: To the	xamination a	and/or investi	gation, in my opinio eath occurred at th	on, death occur e time, date and	red at the time, date	and plac	e, and due to the car	use(s) and manner state	
	<i>V</i>		29b. Signature and title of certifier			29c. License number 03 7016			>	29d. Date signed (Month, Day, Year)			
30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Nearly M. Geers, ms. 671 N. Charles Ht., Such 4129, Nalfman, ms. 21 State Registrar APR 0 5 2011 April 296. Bate signed (Month, Day, Year) 32. Registrar's Signature APR 0 5 2011 April 296. Bate signed (Month, Day, Year) APR 0 5 2011 April 296. Bate signed (Month, Day, Year)											21204		
DHI	Registra	ar	APR 0 5 2011	General ,	8. A	arke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

amend item 19b per fh 914 4-5-11 vt
State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Vear 3:00 AM **Physician** FILISO H 26 GEDRGE MARCH 2011 /Medical 4a, Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Johns Hopkins Bayview Medical Center **Baltimore** Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6 Sex **Funeral** Days Hours 1**XX**M 2 □ F 216-32-8231 73 JAN. 13, MD. Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar more. 10d. Inside City Limits 10a. State 10b. County 10c, City, Town or Location 1 Yes XX No Director BALTIMORE MD. EASTVIEW 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? UNITED STATES 21224 7530 CYPRESS AVE. Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 TMarried 1 ☐ Yes 2√ No WHITE þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) DRIVER MTA BUS STATE 11TH 0 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be MARGARET COLER AARON ELLISON ည 19a. Informant's Name/Relationship (Type. Print)

MAGDALENE

MADELINE

ELLISON/WIFE 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7530 CYPRESS AVE., BALTIMORE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State BALTIMORE, MARYLAND HOLY ROSARY CEMETERY 4/1/2011 4 Donation 5 Other (Specify) 22. Name and Address of Facility CHARLES S. ZEILER & SON, INC. 21. Signature of Fune at Service Licensee 21224 6224 EASTERN AVE., BALTIMORE, MARYLAND Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner as the burial-trar Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, o Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗌 Ectopic pregnancy Day in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 2 No 3 Probably 4 Unknown 1 TYes page 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy 2 No 2 □ No 1 TYes 1 TYes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Be Hospital: 1 - Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 ER/Outpatient 3 DOA မ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Iniury or Attending 1 Yes 2 No death. 2 Accident within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical (check only one) completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D0063303 MARCH 26, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 Eastern Avenue, Baltimore, MD, 21224 32 Registrar's Signature Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2011 Physician/ March 31 1734 p^M Mary E. Flenner Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Harford Upper Chesapeake Medical Center Bel Air If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year) - 1<u>936</u> 1 □ M 2🎞 F Months Days Hours Min Washington D.C. Director 223-42-1054 74 June Usual Residence of Decedent show ms 23a or 28a-f shor must be notified at 10a. State 10b. County 10d. Inside City Limits 10c, City, Town or Location Director 1 Yes 2 X No Harford Maryland Bel Air 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral 1218 Hickory Brook Ct. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian 11. Marital Status the Medical Examiner Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 X Married þ 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Specify: "natural", Completed 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N 12 Years Accounting Bank Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Raymond Slattery Dorothy Declos 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Phil R. Flenner - Husband <u>1218 Hickory Brook Ct.</u> <u>Bel</u> Air, MD 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Bel Air Memorial Gardens 4/5/11 Bel Air, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Service License 610 W. Mac Phail Rd. Bel Air, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Ph_sician/ Medical resulting in death) Due to (or as a conse mence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as Exam attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day Pregnant at time of death signed by the at d be detached for Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has page 2 this certificate 1 Yes 2 No 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? Other: ည 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 1 Natural 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 5 ☐ Pending _Investigation iniury Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie npleted cause of death (Item 23a) (Type, Print) 30. Name and addre Rappake Dr. Bel As State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien@ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** Doris Fiedler March 30, 2011 4:15 P. /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 203 Rolling Brook Way Catonsville Under 1 Year | If Under Baltimore If Under 1 Year Months Days Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Hours Months 1 □ M 2 👿 F 213-32-9264 77 Director March 12,1934 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other than "natural"; or items 23a or 28a-f show other traumatic event, the Medical Examinar must be redified at 1 ☐ Yes 2 ☒ No Director MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code permit. Pages 1 and 2 should be filed within 72 hours after death with t Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or : any injury or other traumatic event, the Medical Examitrant must be an once. 203 Rolling Brook Way 21228 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2X No Specify: Specify: White \$ 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) X-ray Technician Health Care 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Walter Sadowski Mary Galaska ၉ 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carroll J. Fiedler Husband 203 Rolling Brook Way; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State n Forest 4/5/2011 Owings Mills, MD
22. Name and Address of Facility Sterling Ashton Schwah Witzke
Funeral Home of Catonsville, Inc. 4 ☐ Donation 5 ☐ Other (Specify) Garrison Forest 21. Signature of Funeral Service Lenses 1101050 1630 Edmondson Avenue; Catonsville, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) **Physician** 4 MOUTHS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of): Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown Month Day Year 4 ☐ Pregnant at time of death 5 ☐ Other (specify) signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 2 should Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy page certificate 2 NO 1 ☐ Yes 1 ☐ Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 ☐ Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred or Attending Injury 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation the 1 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Box 68760, Division of Vital Records, P.O. To the Hospital or Attend within 24 hours after death To the Funeral Director:

Baltimore, Maryland 21215-0036

29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 828

30. Maine and address of person who completed cause of death (Item 23a) (Type, Plint)

Saltimore MD 21229

31. Date filed (Month, Day, Year)

State Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month O 4 Year 2011 Physician/ 3:28PM Vernon Ervin Freyer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN HOSPITAL BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth g. Birthplace (State or Foreign **Funeral** 1 ☑ M 2 □ F Months 0171271942 Maryland 69 **Director** 215–40–9329 Usual Residence of Decedent or 28a-f show notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director Baltimore 1 Yes 2 X No Maryland Essex 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natural", or items 23a or injury or other traumatic event, the Medical Examiner must be I Funeral 2018 Middleborough Road 21221 U.S.A. 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces Black, White, etc. 1 Never Married 2 Married X Yes 2 No ð Baltimore, Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Specify: Vietnam 3 - Widowed 4 - Divorced White Completed Year or Dates Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) General Motors Assembler Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည William Henry Freyer Ada Mae Zabel permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic once. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2018 Middleborough Road, Essex, Maryland 21221 Mary K. Freyer (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Holly Hill Mem. Gard. 04/07/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signatur. 1 Ft. pd S. m. Licenses 22. Name and Address of Family Inski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Pa ... Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, nock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nediate Cause (Final EREBROVASCULAR ACCIDENT Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Examine Due to (or as a consequence of) nding physician and use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death signed by the at d be detached for g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CEREBROVASCULAR ACCIDENT, HYPERTENSION Records, 1 Yes 2 No 3 Probably 4 Onknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? CORONARY ARTERY DISEASE 24a. Was an has page 2 s autopsy performed To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director: After this certificate it completed filled in by the funeral director, page 1 Yes 2 No Yes 2 N **Division of Vital** 25. Was case referred to medica 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No ၀ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending injury work?
1 Yes 2 No 1 Natural Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) M.D. RESOOO 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) LOCHRAVEN BLUD BALTIMORE MD 21239 5601 NANDINI YADAV APR 0 5 2011 32. Registrar's Signature

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** FEATHERSTONE 04 905 A M BARBARA 2011 03 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore future Care - Charles St. If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Pay,) 8 / 5 / 3 9 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) **Funeral** Months 216-36-2882 1 ☐ M 2 🂢 F Μ̈́D Director Usual Residence of Decedent 10c. City, Town or Location 10a, State 10b. County 10d. Inside City Limits er then "natural", or items 23s or 28s-f show. In Medical Examiner must be notified at N/A Baltimore MD ty Yes 2 □ No Director the th 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21225 2703 Round Road USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes, Give Year or Dates: 14. Race - American Indian. 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc fited within 72 hours after 1 ☐ Never Married 2 ☐ Married African Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Amer. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Self Elementary/Secondary (0-12) College (1-4or 5+) Domestic Engineer 12 other other traumatic event, 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be fift tment of Heelth and Mental Hy tent: If Item 27 Ie marked oth Be Alice Stokes Luke Powell ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Alice Mason/Mother 2703 Round Road, Baltimore, MD 21225 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H Importent: If Ite eny Injury or ot once. 4/11/11 1 ☐ Surial 2 ☐ Cremation 3 ☐ Removal from State Balt., MD Mt. Zion Cem. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Hari P. Close F.S. PA 21. Signature of Fun ral Serv Licensee 5126 Belair Rd, Balt., MD 21206-5105 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician GLIDBLASTOMA MULTIFOIZME /Medical Due to (or as a consequence of): Examiner PROGIZESSIVE DECLINE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examine physicien and the burial-transit The law requires that the death certificate be executed HYPERTENSION resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, BILATERLAL DUE TO CANCETS Physician/Medical MASTECTOMIES use as the attending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 9 1 Yes 2 No 3 Probably 4 donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has b lirector, page 2 s autopsy performed within 24 hours after death.

To the Funerel Director: After this completely filled in hours. 2 19 No 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 41411 MD D31464 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) HASHMI MD 821 N. ENTAW ST SUILE 308 BALTIMORT MD 21201

State Registrar 31. Date filed (Month, Day, Year) APR 0 5 2011 32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month (Physician/ 08:13 Ruth Jean Finley Medical HOW. 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Hospital Hanes Baltimore 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6 Sex . Age (In vrs. last birthday) **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Days 1 □ M 2 🗓 F Min. Hours (Month, Day, Year) 06/19/1931 79 Country) **Director** Yrs. 217-26-6946 WV Usual Residence of Decedent items 23a or 28a-f show ier must be notified at death with the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 🗆 Yes 2 🎦 No Halethorpe 10e Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 5706 Mineral Avenue U.S.A. 21227 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 14 Bace - American Indian Black, White, etc , or ģ 1 ☐ Yes 2 🔀 No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 filed within 72 hours after 1 ☐ Yes 2 🖾 No Specify: "natural" Completed 3 Widowed 4 X Divorced Specify: White Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) McCormick Spice permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Company Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Raymond Elkins Cain Sr. Ruth Elizabeth Custer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Raymond E. Cain Jr. 126 Rosewood Ave., Catonsville, MD 21228 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 4 Donation 5 7 Other (Specify) Edge Hill Cem. 4/4/11 Charles Town, WV 22. Name and Address of Facility Melvin T. Strider F.H. Mildred St., Charles Town, WV 25414 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Speet and Death Physician/ Dreumon disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner ere brovascular accident Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Masma Gto m Due to (or as a consequence of) resulting in death) Last Physician/Medical Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Finley 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

1 Yes 2 No certificate 1 ☐ Yes 2X No Division of Vital eral Director: After this certific filled in by the funeral director, the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 Yes 2 No မှု 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending injury Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide within 24 hours a To the Funeral I Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) thei Wang 01 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ming Wana -Hs: 900 Baltimore. Caton Ave. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death Year Physician/ 2:05 PM -erguson ADYL 201 Medical mono a. Facility Name (if not institution, give street and number) 4b. City Town, or Location of Death 4c. County of Death Examiner If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth 7. Age (In yrs. last birthdav) If Under 1 Year **Funeral** (Month, Day, Months Min. Country) Director Usual Residence of Decedent 10a. State 10d. Inside City Limits 10b. County 10c. City, Town or Location Page 1 and 2 should be filed within 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Completed by Funeral Director Baltimore 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21218 "natural", or items 23a USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Maryland 21215-0036 Specify: Black Specify. 3 Widowed 4 Divorced any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Important: If item 27 is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Horse Race Track Groome Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ 19a. Informant's Name/Relationship (Type, Frint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Balton MA Ferguson-Daughte navmonette Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Greenmount Cemetery Baltimore, MD 4-9-2011 22. Name and Address of Facility March F/H 1101 E. North Ave. 21. Signature of Fundal Service Licensee Baltimore, 21202 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Cardiovascolar Physician/ Acute disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Smoking Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death. Bron Chronic attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Breast Division of Vital Records, P.O. Box 68760 IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No
9 Unknown Month Dav Year After this certificate has been signed by the a funeral director, page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 🗌 Yes 2 🗌 No 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ 1 Inpatient 2 KER/Outpatient 3 IDOA 27. Manner of Death 1 Natural 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Yes 2 No thin 24 hours after death.

the Funeral Director: A mpleted filled in by the fu Accident Suicide Investigation Could not be . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier N P son who completed cause of death (Item 23a) (Type, Print) STOKES MI 0 5 2011 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Lillian Galloway Physician/ 2091 April 1 10:00aM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore Riverview Nursing Center Essex Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 😾 F Days Months 058-18-2009 87 Yrs Director 1923 NY Dec. Usual Residence of Decedent 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director ral", or items 23a or 28a-f s Examiner must be notified Middle River Baltimore MD 1 Yes 2 XNo 10e Street and Number 10f, Zip Code 10g. Citizen of What Country? 21220 Funeral USA 70 Transverse Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 No Specify. Specify: White "natural" Completed 3 X Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) the own home Homemaker Be 17. Father's Name (First, Middle, Last) permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked out any injury or other traumatic event 18. Mother's Name (First, Middle, Maiden Surname) 2 Lorentzen Ragna Frank Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 386 Foreland Garth Abington MD 21009 Saada Russell /daughter Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🔀 Burial 2 🗌 Cremation 3 🗆 Removal from State Holly Hill Cemetery 4/6/11 Baltimore MD 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 300 Mace Ave._Balto. Signal re f Funeral Survice Licensee Connelly Funeral Home of Essex 21221 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, shock, or heart failure. List only one muse on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ REBRO VASCULA disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of) that initiated events Hospital or Attending Physician: The law requires that the death certificate be exected to be consistent death.
 Funeral Director: After this certificate has been signed by the attending physician an effect filled in by the funeral director, page 2 should be detached for use as the burial-tried filled in by the funeral director, page 2 should be detached for use as the burial-tried. Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Pregnant at time of death 2 No Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? Was an autopsy 24 No Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death Check only one) examiner? Hospital: Other: 2 No မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 27. Manner of Death 28b. Time of Certificate: 28d. Describe how injury occurred Naturai iniury 5 Pending 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State within 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month. Dav. Year) 28595 elle 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar ASNEEM

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- State amend 6 per hosp. g918 8/26/certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month :35 **Physician** PM 2011 Dr Sath Ghani /Medical Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Agne MOS IMPYE 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, **Funeral** Days Hours Min **X**□ M 2 □ F Yrs. N/A Director MD 8 3/24/11 Usual Residence of Decedent death with the Maryland 10d. Inside City Limits 10a. State 10h County 10c. City, Town or Location 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Modical Examiner must be notified at 1 ☐ Yes 2K No Director Baltimore Catonsville MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 317 Winter Lane Apt A 21228 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status filed within 72 hours after Hygiene. 1 ∐Yes 2 XNo If Yes, Give Year or Dates: 1 V Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐Yes 2 No Specify. Specify: Asian þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Mohammad Ghani Abida Bb ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) is ma 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2. Department of Health a Important: If item 27 is any injury or other trau once. Mohammad Ghani/father 317 Winter Lane Catonsville, MD 21228 20c Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/2/11 Park Baltimore, MD King Mem. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee 4300 Wabash Ave March Funeral Home WestBaltimore, Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final day **Physician** neepha disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter or denying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine law requires that the death certificate be executed and Due to (or as a consequence of): of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ☐ Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 1 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 ☐ Yes 2 📈 No 2 🗆 No Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Division Hospital or Attending 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director; 6 □Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a

To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a, Certifier (Check only and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registra Year)

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death Day 2011 Physician/ Month Gallahan Judson Lee 30 March 11:40 å Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Baltimore <u>Maryland Masonic Home</u> Cockeysville If Under 1 Year 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthdav) If Under 24 Hrs **Funeral** Months Days Hours 1 X M 2 - F 90 Virginia Yrs. Director 224-07-3736 Usual Residence of Decedent items 23a or 28a-f show ner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 X No Cockeysville Baltimore MD 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A 21030 300 International Circle, Unit 203 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Page 1 and 2 should be filed within 72 hours after deat Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other traumatic event, the Medical Examiner! Armed Forces? Black, White, etc. 1 Never Married 2 X Married Completed by Saltimore, Maryland 21215-0036 If Yes, Give WW II 1 Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Field Sales Rep Trading Stamps Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Cooper Jacob Gallahan Anna Judson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3517 Waverly Dr., Fredericksburg, VA Sharon Bell-daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (Specify) Entombment 4/4/11 Timonium, MD Dulaney Valley 21. Signature of Funeral Service Licensee William G. 22. Name and Address of Facility Ruck Towson Funeral Home, Dau 1050 York Rd Towson. MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Stag Demertia Onset and Death Immediate Cause (Final End Physician/ sen disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year signed by the at d be detached for Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Lunknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 After this certificate 1 ☐ Yes 2 XÎNo 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 2 XNo Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury 1 Alatural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Hospital Medical 1 🕰 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License numbe 29d. Date signed (Month. Day, Year)

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State Registrar 3508

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03 30 2011 Gigliotti, Jr. Joseph Vincent 9:25 P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Baltimore Washington Medical Center Glen Burnie 7. Age (In yrs. last birthday) Social Security Number If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Months Days Hours Min. Country) **Director** 85 213-20-5709 PA Usual Residence of Decedent 28a-f shov 10a. State 10d. Inside City Limits 10c. City. Town or Location ir than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 Yes 2X No Glen Burnie Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 229 21061 U.S.A. St. James Drive Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Armed Force Black White etc. 1 √ Yes 2 □ No If Yes, Give 2 1 Never Married 2 Married should be filed within 72 hours after and Mental Hygiene. Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: Completed 3 Widowed 4 Divorced Year or Dates White 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Brick Mason Masonry other traumatic event. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Joseph V. Gigliotti, Sr. Gladys Laney 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 st Department of Health a Important: If item 27 is any injury or other trau Mrs. Joni Miller / daughter Harmans Road Hanover, Maryland 21076 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XBurlal 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/6/2011 Dudalk, Maryland Sacred Heart of Jesus 21. Signature of Funeral Service Licenses 22. Name and Address of Facility 1 2nd Ave, SWGlen Burnie, MD Van work Singleton Funeral & Cremation SErvices, P.A. 0/357 23a. Part 1. E 🔭 📲 disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death / Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions if any, reading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a conseduence of use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy signed by the atte in the past 12 months?

1 Yes 2 No Month Day 4 Pregnant 9 Unknown 5 Other (specify) Year Pregnant at time of death 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 3 Probably 4 Unknown 1 Tyes No 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death?

1 Yes 2 No this certificate has all director, page 2 performed? Yes 2 To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific Division of Vital 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 횬 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manper of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Matural Natural 5 - Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: lothe best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D25611 3/31/2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) A #300 Glen Burnie, Md 21061

State Registrar

Box 68760

P.O.

Kaplan

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 20 1°1′ George Grahe 2:34A Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 305 S. Camp Meade Road Linthicum Heights Anne Arundel . Social Security Number 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Country) MD Hours May 21, Year 22 88 Director 215-14-8936 Usual Residence of Decedent or 28a-f show 10a. State ortant: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director Anne Arundel Linthicum Heights 1 Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 305 S. Camp Meade Road 21090 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black. White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 XNo If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: White 3X Widowed 4 ☐ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Machinest Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ George C. Grahe Sr. Willie Mae Conner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Mrs Sandra Kraft/Daughter 815 Fifth Avenue Halethorpe Maryland 21227 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State April ate7, cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) 2011 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave.SW Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Lung Metastasis disease or condition Medical resulting in death) Examiner ureteral Cancel Metastaho Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ___ in the past 12 months? Month Pregnant at time of death Day 2 🗌 No 1 Yes 2 L g Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas performed certificate Yes 2 No 1 Yes 2 No the Hospital or Attending Physician: 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) a No Hospital Other: 1 Yes ပ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pendina after death.

Director: Aft in by the fur Accident
Suicide
Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D0052490 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SOUR HEADER St. BAILTING MD 21225 Khandelwar 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March Physician/ 20°11 5:34 Рм Elizabeth Catherine Grover Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Heritage Nursing Home 9. Birthplace (State or Foreign If Linder 1 Year If Linder 24 Hrs. . Age (In yrs. last birthday, 8. Date of Birth Funeral (Month, Day, Ye Min Country) Maryland Hours Months 216-24-2120 1 ☐ M 2 💢 F Ĩ928 Director ulv Usual Residence of Decedent or 28a-f show notified at 10d Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mertal Hygiene.
Important: If item 27 is marked by the Than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City. Town or Location Director 1 X Yes 2 No Baltimore MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21225 420 Freeman St. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1 Yes 2 If Yes, Give Year or Dates. 1 Never Married 2 Married 2 XNo Completed by Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2X No Specify. 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Baltimore City Elementary/Seconday (0-12) College (1-4 or 5+) Public Schools custodial Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Madilane Appel Charles V. Hodges 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10032 Crane Ln; Baltimore, Maryland 21220 19a. Informant's Name/Relationship (Type, Print) Harold Schofield 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☒ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility State Anatomy Board Signature of Funeral Service Roma Ld Director 655 W. Baltimore St; Baltimore, MD 21201 3a. Part 1. Inter the disease or implications that caused shock, or leart failure. List only one cause on each line. Immediate Caus. In Final mplications that caused the death. Do not enter the mode of dying, such Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician; The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Day Month Pregnant at time of death cate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobaceo use contribute to the cause of death? Completed by 3 Probably 4 Unknown 2 No ASCULAR DISEASE 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy certificate 1 ☐ Yes 2 ☐ No director, 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Other: 2 1 No 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ဂ္ After this 27. Man of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending Natural 2 🗌 No 1 Yes death. Investigation 6 Could not be Accident within 24 hours after death

To the Funeral Director:
completed filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Homicide City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and little of certifie 29d, Date signed (Month, Day, Year) 32. Registrar's S State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ WILLIAM L. HENN, SR. APRIL $2\check{O}I^{r}1$ 9:35 A M Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City, Town, or Location of Death STELLA MARIS TIMONIUM BALTIMORE 5. Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1**x** M 2 □ F Months Days Hours SEPT. Day Year) 925 213-20-8266 85 Director MD Usual Residence of Decedent Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified MD N/A 1 X Yes 2 No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6002 WALTHER AVE 21206 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?
1 X Yes 2 No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Never Married 2 Married Completed by 21215-0036 WHITE 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3X Widowed 4 □ Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 SHEET METAL WORKER IINTON Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) NORMAN HENN MAUDE FORREST 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau WILLIAM HENN, JR.-SON 7846 ELLENHAM RD BALTIMORE, MD 21204 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State PARKWOOD CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 4/7/11 BALTIMORE, MD 22. Name and Address of Facility MILLER-DIPPEL FUNERAL HOME, 6415 BELAIR RD BALTIMORE, MD 21206 23a. Part 1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure list only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition 2 day Medical resulting in death) **Examiner** CONS Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Examine resulting in death) Last Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be exec Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Other 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury work? 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. reis CRIT R043580 04-04-2011 Justine

State Registrar

WILLIAM

9:35

DHMH 17 Rev 7/2009

2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

CRNP

JUSTINE PREIS,

APR 0 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death April Physician/ **02** Day Cecil L. Hostinek 2011[~] 11:05A.M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Timonium Baltimore County Stella Maris Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** (Month, Day, Year) Tune 13,1915 Months Days Hours Baltimore, MD. 214-01-8157 95 Director June Usual Residence of Decedent or 28a-f shov notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Maryland Baltimore County Cockeysville 1 Ves 2 No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code of Health and Mental Hygiene. item 27 is marked other than "natural", or items 23a or other traumatic event, the Medical Examiner must be in Funeral 302 Wickersham Wav 21030 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12 Was Decedent Ever in U.S. 14 Bace - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. Completed by 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Year or Dates White 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12 N/A Secretary Morgan Bare Orchestra Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked of any injury or other traumatic eve မ Percy Thomas Leitch Elizabeth Virginia Kimes 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 302 Wickersham Way Cockeysville, MD. 21030 Mrs. Betty A. Wofford (Daughter) Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Tuesday, 20c. Location - City or Town, State (Harford County) 200. Place of Dispositivity of the place)

Evans Funeral Chapel and
Cremation Services, Inc. 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) April 05,2011 Forest Hill, Maryland Signature of Funeral Service Licensee Jeffrey L. Gair, Sr. Percentil Alternatives Funeral and Cremation Center, P.A. 2325 York Road Timonium, Maryland 21093-2215 Lic.#M00677 23a. Fal. 1 Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Onsat and Death Immediate Cause (Final Enysician/ DUNI disease or condition Medical resulting in death) **Examiner** Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of attending physician and for use as the burial-tran Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year 5 Other (specify) Pregnant at time of death be detached been signed by the Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 ☐ Probably 4 ☐ Unknown Division of Vital Records, 1 🗌 Yes completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗌 No Yes Yes To the Hospital or Attending Physician: \ within 24 hours after death. To the Funeral Director: After this certifica Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 Tyes 2 🗆 No 2 Accident
3 Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 X Certifying Nurse Practioner: To the best of my knowledge, de eath occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I only one) 29b. Signature and title of certifier

Registrar
DHMH 17 Rev 7/2009

State

HOSTINEK

32. Registrar's Signature

2300 DULANEY VALLEY ROAD

TIMONIUM, MD 21093

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

CRNP

JUSTINE PREIS,

Date filed (Month, Day, Year)

APR 0 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Month 3 Physician/ Year 20:30 M Hicks Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 20 Cerner Boltimore MD Medical Baltimore If Under 1 Year If Under 24 Hrs. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth Funeral 1 🗆 M 2 🗓 F Days Min. 07-10-2 Country) 86 219-22-4145 Director VA Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. In the Mathan 17 is marked other than "natural", or items 23a or 28a-1 shoilary or other traumatic event, the Medical Examiner must be notified at 10a. State 10h County 10c. City, Town or Location 10d. Inside City Limits Director Baltimore NA MD 1 X Yes 2 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? #218 Funeral 1700 Edmondson Avenue Apt. USA 21223 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 14. Race - American Indian Black, White, etc. African Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) þ 1 Never Married 2 Married Maryland 21215-0036 1 Yes 2XXNo Specify: Specify: American 3 X Widowed 4 ☐ Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Towson State Elementary/Seconday (0-12) 9th Grade Laborer University Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Turner Elev Porter Ruth 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) North Ann Street Baltimore, MD 21231 Brenda Dorsey-Cousin Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of H Important: If ite any injury or oth 1 X Burial 2 Cremation 3 Removal from State 04-07-11 Baltimore, MD Baltimore Nat 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ CVA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed the attending physician and hed for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death 9 Unknown this certificate has been signed by a director, page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No deatn? 1 ☐ Yes 2 🕱 No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) examiner? Hospital Other: 2 00 1 🗌 Yes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify, Manner of Death Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer (Month, Day, Year) work? Natural 5 Pendina Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certif 187181833G 1291 M.D. 30. Name and address of person completed cause of death (Item 23a) (Type, Print) Greene 21201 Battimore 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Marianne R. Hart Physician/ Month : 55A M 3 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Good Samaritan Hospital N/A Baltimore 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) PA Months Hours Min Sept 19,1926 Director 220-20-1796 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location **Funeral Director** MD N/A Baltimore 1 XXYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3105 White Avenue 21214 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 XNo 1 ☐ Yes 2XX No Specify: Specify: White "natural", 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any Injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b, Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Charles W. Rabette Susan McLaughlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Millard Hart, Sr. (Husband) 3105 White Avenue Baltimore, MD 21214 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/5/11 Glen Burnie, MD Atlantic Crematory 21. Signature of Funeral Service Liceps 22. Name and Address of Facility 3631 Falls Rd. Balto, MD 21211 Burgee-Henss-Seitz runeral Home, Inc. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease Approximate Interval Betweer Immediate Cause (Final Onset and Death Physician/ Q disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Pregnant at time of death Other (specify) Year ed by the a detached f Unknown signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ፩ been signature should to 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an cate has t autopsy performe After this certificate he funeral director, page 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) မှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? 5 Pending Accident Investigation within 24 hours after death

To the Funeral Director: of completed filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Homicide determined City or Town, State) Medical 1 🗡 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month. Day, Year) who completed cause of death (Item 23a) (Type, Print) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Wanda Kate Harreld 11:20AM Medical 2011 March 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death 706 Bradford Lane Abingdon Harford 5. Social Security Number **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Nov. 2, 1933 1 🗆 M 2 🕱 F Days Months Min. Hours **Director** Virginia 229-44-2835 77 Usual Residence of Decedent show and Mental Hygiene. is marked other than "natural", or items 23a or 28a f shor raumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Maryland Harford Abingdon 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 706 Bradford Lane 21009 USA death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. 1 Never Married 2 X Married δ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced 4 Divorced Specify: Completed White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 11 Food Demonstrator Wholesale Distributor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 James Earl Wilson Georgia Lee Cress traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s f Health item 27 Asher D. Harreld / Husband 706 Bradford La., Abingdon, Maryland 21009 injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, permit. Page 1 a
Department of I
Important: If ite
any injury or ot 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 Donation 5 Other (Specify) Sunset Memorial Park 4-4-11 Damascus, Virginia 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McComas Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Maryland 21009 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition 400 Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last burial-tran Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 the for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ 23d. Date of delivery in the past 12 months Month Pregnant at time of death Day Year hed the 9 Unknown been signed by t should be detact ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? has page 2 autopsy performed? this certificate 1 Yes 2 No director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: ည 1 Yes ER/Outpatient 3 DOA 1 🗌 Inpatient 2 🗌 4 Nursing Home 5 X Residence 6 Other (Specify) funeral 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at After 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No the Accident Investigation Suicide Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

To the Hospital or Attendii within 24 hours after death. To the Funeral Director: A

State

Registrar

only one) 29b. Signature and sittle of certifie

Ashkan Bahrani, MD

31. Date filed (Month, Day, Year,

32 Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

2 Medical Examiner: On the basis of examination and/or investigation, in his opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

602 S. Atwood Road, Bel Air, Maryland 21014

29d. Daye signed (Month, Day, Year) 30

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene (For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 Agnes Harding 2:00 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Stella Maris Timonium Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. Month, Day, 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 □ M 2**XX**F (Month, Day, Year) Mary Tand Director 212-24-9923 96 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10d. Inside City Limits with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location Director Maryland Baltimore Towson 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 609 St. Francis Road 21286 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: If Yes, Give Completed 3 X Widowed 4 Divorced Year or Dates injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit Page 1 and 2 should be filled within 7 Department of Health and Mental Hygiene. Important If Item 27 is marked other than any injury or other trainmosts. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည J.Edward Hibline Helene Emma Knackstedt 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helene Psotto / Daughter 6607 Collinsdale Road C, Baltimore, Maryland 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp 4/6/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fungral Service Licenses 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death BRONAR Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Box 68760 the Hospital or Attending Physician: The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Dav 5 Other (specify) Pregnant at time of death signed by the a Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 2 No 1 🗌 Yes 3 Probably 4 Unknown Division of Vital Records, Completed 24b. Were autopsy findings available 24a. Was an cate has I autopsy performada Yes 2 No prior to completion of cause of death?

1 Yes 2 No certificate 25. Was case referred to medica 26. Place of Death (Check only one) Be examiner? Hospital 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) within 24 hours after death.

To the Funeral Director: After this 28a. Date of injury (Month, Day, Year) 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28b. Time of funeral Certificate: 1 Natural 28d. Describe how injury occurred iniury 5 Pending Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) send CRI -201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY ROAD TIMONIUM, MD 21093 JUSTINE PREIS, CRNP 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 2 Year JOHN . T. HAMMACK 8:55 PM M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** FRIENDS NULSING OWEY, MONTGOMERY 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** May 14, Year 929 243-44-1731 1 M 2 - F Months Hours North Carolina 81 Director Usual Residence of Decedent 28a-f show 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Montgomery Bethesda 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral #713 20814 4977 Battery Lane USA within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11 Marital Status Armed Forces? 1 X Yes 2 ☐ No þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: If Yes. Give Specify: White **'**59-61 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event, the Mery injury or other traumatic event. psychologist healthcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျ Avhlee Elizabeth McCuiston William Thomas Hammack 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4901 Tremont Drive Raleigh, NC 27609 19a. Informant's Name/Relationship (Type, Print) Frances H. A. Read/cousin 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4
☐ Other (Specify) रिवार के तिमान के जिल्ला Board 655 W. Baltimore Street Director 21201 Baltimore, MD 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CANLER OF ESOPHAGUS Physician/ MONTHS disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Cther (specify) in the past 12 months? Month Year signed by the a detached f g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by FAIWLE 10 MAVE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 'No Other: Nursing Home 5 Residence 6 Other (Specify) မ 1 Inpatient 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 Pending injury 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: Ai
completed filled in by the fu 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State, Medical 29a. Certifier ivaricertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) K. Small sunda 3-29-2011 1253367 SHYAMSUNDAR RAJAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) GEORGIA AVENUE,

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

P.O. Box 68760

Records,

Division of Vital

SIMMSPRING

\$4 ME: 117

32. Registrar's Signatur

			For State	State of M	laryland / Dep	artment o		ınd Mental Hy	2011	10773
		-	Registrar 1. Decedent's Name (First, Middle, La	st)		Tuncate	or Dealir	2. Date of De	Reg. No. U	3. Time of Death
The state of the s	Physici	_	DOROTHY	G	HELLMAN			april	Pay 20/1	1:20 AM
P. Salda	/Medic		4a. Facility Name (If not institution, give			4b. Cify, Tov	vn, or Location o	f Death	4c. County of Dea	ath
	Zamin		ROLAND PARK PLAC	E		BALT	IMORE		N/A	
	Funeral		Social Security Number 6. S	Sex 7. A 1 □ M 2 🔀 F	ge (In yrs. last birthday) If Under 1 Y Months Da	ear If Under 2 ays Hours	Min. (Month, D.	ay, Year)	rthplace (State or Foreign ountry)
١.	Director		090-14-0865 Usual Residence of Decedent		98 ^{Yrs.}			11/21	/1912	NJ
	/land ow at	Funeral Director	10a. State 10b. County		10c. City, Town or I	ocation				10d. Inside City Limits
	a-f sh		MD N/A		BALTIMO	RE				1 X Yes 2 □ No
	or 28		10e. Street and Number	 		10f. Zip Co	de		10g. Citizen of What C	ountry?
	23a ust b		830 WEST 40TH S			212			n- 14. Race - Am	USA
	ier de	nne	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Deceder Armed Forces 1 ☐ Yes 2 ②				gin? (Specify Yes or No., Puerto Rican, etc.)	Black, Wh	
36	urs aff	by	3 X Widowed 4 Divorced	If Yes, Give Year or Dates		1 □ Yes 2 🔼	No Specify:		Specify:	ITE
21215-0036	filed within 72 hours after death with the Maryland Hygiene. ther than "natural" or Items 23a or 28a-f show ent, the Medical Examiner must be notified at	Completed	15. Decedent's E (Specify only highest gr		16a. Dec	edent's Usual O	ccupation lone during most	t of working	16b. Kind of Busines	
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anc	d be fi	Be c	17. Father's Name (First, Middle, Last JACOB)	GURKI	ī	HEL	,		CHENKEL
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Infinitely of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or thems 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at once.	욘	19a. Informant's Name/Relationship	(Type. Print)					ber, City or Town, State,	
Z	1 and 2 s Health ar em 27 Is other trau		JESSE HELLMAN /	SON	140	O WINE	SPRING	LANE, BALT	IMORE, MD 2	1204
Baltimore,	es 1 a of Hei item		20a. Method of Disposition	70	20b. Place of Disp		of	Date	20c. Location - City of	
<u>m</u>	Pages nent of H ant: If ite ury or of		1 ☐ Burial 2 🛣 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		CARROLL			04/03/2011		
alt	permit. Departr Importa any inje		21. Signatur of Funeral Service Life	ee					SON & BROS	
	205 20	0. "	William 13	uger	1	8900 RE	EISTERST	OWN ROAD,	PIKESVILLE	
	hysician		23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final	one cause on each	ine.	nter trie mode o	r dying, such as	cardiac or respiratory	arrest,	Approximate Interval Between Onset and Death
The same of	/Medical		disease or condition resulting in death)	Due to (or a	s a consequence of):		_			/
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89	tificate g phy as the	edic		и,			21/2			
Вох	leath certifica attending ph I for use as tt	N/ue	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom		□Ectopic pregr	nancv		23d. Date of d	
О.	Attending Physician: The law requires that the death certificate be executed refeath. After this certificate has been signed by the attending physician and ector. After this certificate has been signed by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown			Other (special			Month	Day Year
P.O.	hat th d by t letach	Ph		contributing to death	but not resulting in the	underlying caus	e given in Part I	23e. Did	tobacco use contribute	to the cause of death?
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CO	w requir been si should	Completed						24a. Wa	s an 24b. Were	autopsy findings available
Be	he lar e has age 2	duc						aut	opsy prior t formed? death	completion of cause of
ta	an: T tificat tor, pa	Be Co	25. Was case referred to medical				26. Place	1 Yes ef Death (Check only		es 2□No
<u>-</u>	ding Physician: The lav. n. After this certificate has funeral director, page 2	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 ☐ Inpa	tient 2 ER/Outpati	ent 3 DOA	Other: 4 Nu	rsing Home 5 Res	sidence 6 Other (S	pecify)
0 0	ng Pt fter tt ineral		27. Man of Death 1 ✓ Natural 5 ☐ Pending	28a. Date of Ir (Month, I	jury 28b. Time Day Year) Injury		Injury at Work?		how injury occurred	
Sio	tendleath. tor: A	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be		A h	M	1 ☐ Yes 2 ☐		(Chan and a said \$6.500 has a said	Donal Davida Morahan
Division or Vital Records,	or At after d Direc in by	Certification:	4 ☐ Homicide determined	28e. Place of a	njury - At home, farm, s etc. <i>(Specify)</i>	street, ractory, or	nice		(Street and Number or own, State)	Hurai Houte Number,
_	To the Ospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the								e cause(s) and manner	
	n 24 h ne Fui oletel)	Medical	(Check only 2 ☐ Medical Exa	miner: On the basis and manner		investigation, in	my opinion, dea	ath occurred at the time	e, date and place, and o	ue to the cause(s)
	Within To the comp	ž	29b. Signature and title of certifier	· 040 0	44 15 3		icense number		29d. Date signed (Mo	
			D Babelle Va	949	er 17)	D	13657		april 1, 26	11
)			30. Name and address of person who no DABETTE THE	SREGER,	death (Item 23a) (Type 700 W- +	e, Print) O M S TR	EET, B	ALTIMIRE,	mo 212/1	
	Sta Registi		31. Date filed (Month, Day, Year) APR 0 5 201		strar's Signature					-

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND PITEM#19a, Perfft, G914, 4/8/2011, WS

State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** Gloria C. _{Isensee} Ye ar 2011 Ĺ /Medical 4c. County of Death Examiner 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death ROSECICIE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year December 30, 1927 Franklin Square Hospital Bal more 9. Birthplace (State or Foreign Country) Maryland 5. Social Security Number 6. Sex . Age (In yrs. last birthdav) **Funeral** 1 □ M 2 ▼F 214-22-2938 83 Director Usual Residence of Decedent 10b. County It is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Exandrier must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Md. Balto. Nottingham 1 ☐ Yes 2 XNo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 7718 Bennerton Drive 21236 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ▼ No 11. Marital Status Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates: 1 ☐Yes 2 ☑ No Specify. Completed by Specify White 3 √ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be f nent of Health and Mental ပ္ Frank A. Snyder Mary E. Stewart 19a. Informant's Name/Relationship (Type. Print)
Richard Isensee 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27 is r Rick Isensed Important: If Item 27 any Injury or other t Son 7718 Bennerton Drive Nottingham, Md. 21236 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4-4-2011 Bayview Balto. Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 41 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Due to (or as a consequence of): disease or condition resulting in death) /Medical Examiner Congest Samunitely list and differential any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be execut burial-trai Division of Vital Records, P.O. Box 68760 💆 Due to (or as a consequence of): attending physician Physician/Medical the as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy for in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Dav 5 Other (specify) the 9 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? q 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 2 X No 1 ☐ Yes 2 ☐ No 1 □ Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To npatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of Injury (Month, Day, Year) After t 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 00069684 MKelly 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud; Baltimore MD 9000 Franklin Square . KEIT Registrar's Signatu 31. Date filed (Month State Registrar

Sensee

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Day Month 8:45 A M Physician 11 /Medical Facility Name (If not institution, give st 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore lowson) wane If Under 1 Year | If Unde 6. Sex vrs. last birthday) Security Number **Funeral** Months 1□M 2**T**F 219-16-3394 86 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits "natural", or items 23a or 28a-f show edical Examiner must be notifled at 1 ☐Yes 2X No Director OWSON 10g. Citizen of What Country? 10f. Zip Code 21201 Jest Funeral · death v 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc filed within 72 hours after Hygiene. 1 Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🗷 No Specify ģ 3 ☑ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry the Medical 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life: BQ NOT use retired) idary (0-12) College (1-4or 5+) *lomestic* permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien Important; If Item 27 is marked other the any injury or other traumer. Father's Name (First, Middle, 18. Mother's Name (First, Middle, Maiden Surname, , ldre 19a Informant's Name/Relationship (Type. Prjr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ct., Nottingham Daughter) 5 Camero 20b. Place of Disposition (Name of lynes Date 20a. Method of Di position cemetery, crematory 1 Burial 2 □ Cremation 3 □ Removal from State 4-8-2011 Owings NI:16 noomse 4 Donation 5 Other (Specify) 22. Notarray front Fally. Greene tuneral Services 21. Signature of Funeral Service Licensee 5151 Balto. Nat'I Pike (21229) 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Physician o conor 4 /Medical Due to (or as a cons que ce of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit ementia and Due to (or as a consequence of) Box 68760, attending physician certificate be Physician/Medical the t use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months?
1 Yes 2 DNo
9 Unknown for Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □Yes 2☒ No 24a. Was an has autopsy page ; certificate 1□ Yes 2 No Division or Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA 2 To the Hospital or Attending Phys within 24 hours after death.

To the Funeral Director; After this completely filled in by the funeral dir 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3∏ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier Medical (Check only one)

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

Asadi

DHMH 17 Rev 1/2001

ORIGINAL

who completed cause of death (Item 23a) (Type, Print)

32. Pegistrar's Signature

3029

29c. License number

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** 20.20 PM JAMES JONES APRIL 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center Baltimore 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min. 215-16-0439 Director 88 July 9,1922 Maryland Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 Is marked other than "natural", or Items 23a or 28a-f show any Injury or other traumatic event, the Medical Examiner must be notified at anone. 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 1 ☐ Yes 2X No Director Md. Balto. White Marsh 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 5301 Bush Street Funeral 21162 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊈Yes 2 □ No If Yes, Give Year or Dates: 1944–1946 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: þ Specify: White 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Heating & Air Elementary/Secondary (0-12) College (1-4 or 5+) Metal Worker Conditioning 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter C. Jones ည Alverdia Crumrine 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terri L. Yeager DTR. 9531 Horn Avneue Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hills 4-6-2011 4 ☐ Donation 5 ☐ Other (Specify) Middle River, Md. 22. Name and Address of Facility Schimunek FuneralHome 21. Signature of Funeral Service Licenses 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician RESPIRATORY FAILURE disease or condition resulting in death) 10 HOURS /Medical Due to (or as a consequence of): Examiner IWEEK PNEUMONIA Sequentially list conditions, if any local by translate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit IMONTH law requires that the death certificate be executed ASPIRATION resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 - Fetal death 3 - Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) d by the at detached f Yes 2 No 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CONGESTINE HEART FAILURE 1 🗌 Yes 2 ☐ No 3 ☐ Probably 4 ☑ Únknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has bu autopsy performed 2 VNo 1 Yes 2 Wo Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 \(\) Nursing Home \(5 \) Residence \(6 \) Other (Specify) 1 ☐ Yes 2 No 2 ER/Outpatient 3 DOA ၉ filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation Injury 1 ☐ Yes 2 ☐ No death. 2 Accident after death Director: 3 Suicide 6 ☐ Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specity) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours a 29a. Certifier 1 Ecertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

To the Hosp within 24 hou To the Funer completely fil

State Registrar 29b. Signature and title of certifier

VENKAT

31. Date filed (Month, Day, Year)

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backer

(HOSPITALIST)

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

GUNDAR EDD'

29c. License number

D70728

29d. Date signed (Month, Day, Year)

APRIL 2, 2011

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year Physician/ 6:35A M Johnson Jearl 2011 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Summit Park Nursing Home Catonsville Baltimore Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number If Under 8. Date of Birth 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Min. July 5, 1916 1 □ M 2 K I Months Hours 212-10-2742 94 Maryland **Director** Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 72 hours after death with the Maryland Director 1 🗆 Yes 2🏋 No MD Baltimore Upperco 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 17405 Pleasant Meadow Road 21155 USA "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify. Completed 3 X Widowed 4 Divorced the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene.

is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Linder Margaret Schultz 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau Linda Schmidt 17405 Pleasant Meadow Road; Upperco, MD 21155 20b. Place of Disposition (Name of Cametery, crematory or other place)

Loudon Park Cemetery 4/5/2011 20a. Method of Disposition 20c. Location - City or Town, State ■ Burial 2 ☐ Cremation 3 ☐ Removal from State Baltimore, MD ■ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. Signalure of Funeral Service L 1630 Edmondson Avenue; Catonsville 21228 23a. Part 1. Enter the disease, o complications that caused shock, or heart failure. List only one cause on each line. complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Retween Onset and Death Cardiovascular Disease Immediate Cause (Final Physician/ Atherosclentic disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Due to for as a noneconnector Examin the Hospital or Attending Physician: The law requires that the death certificate be executed thin 24 hours after death.

the Funeral Director. After this certificate has been signed by the attending physician and mpleted filled in by the funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year 4 Pregnant at time of death g Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown icate has been siç ; page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: Other: 2 🗹 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred ė 1 Natural 5 Pending Certificat 1 Tyes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a To the Funeral D Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ns Rijapahil M.D DO057465 4/1/11

State

, Baltimore, MD. 21209.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

2835 Smith

wa

N. S. Rajapak Se, M.D

1. Date filed (Month,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ APRIL 4:45 P.M. Joseph Gordon Donald Jones Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KOSEDALE RANKLIN BALTIMORE HOSPITAL QUARE If Under 1 Year If Under 24 Hrs. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1**XX**M 2 □ F Months Hours Min. 06/21/1926 Maryland 84 Yrs. **Director** 220-18-4023 Usual Residence of Decedent 28a-f shov 10a. State 10b. County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director must be notified 1 Yes 2XNo Maryland Baltimore Essex 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? ò 23a Funeral 304 Miles Road 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. 1944 9 δ 1 Never Married 2 X Married 1XXYes 2 □ No 1 ☐ Yes 2 XNo Specify. If Yes, Give 1946 Specify: White 3 Widowed 4 Divorced Completed Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If Item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 8 Police Officer Baltimore County Be Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ Albert Jones Annie Buckingham 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Virginia Jones (Wife) 304 Miles Road, Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Bayview Crematory 04/05/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Signature of Fundal Service Coenses 22. Name and Address of Facility Bruzdzinski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 23a. Part 1 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death DAYS Immediate Cause (Final dis ase or condition resulting in death) Physician/ LROSEPSIS Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): use as the burial-transi Cause (Disease or impury that initiated events Due to (or as a consequence of) resulting in death) Last Certificate: To Be Completed by Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 bours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in by the funeral director, page 2 should be detached for use as the burn completed filled in the state of the state Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Pregnant at time of death Yes 2 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, 1 🗌 Yes 2No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1. ■Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No 2 Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical Exertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Dotraut a.M. aillie DBCCCB 03 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9000 FRANKLIN SQUARE DRIVE BALTIMORE MD WILLES 31. Date filed (Month, Day, Year) 32. Registrar's Signature

DHMH 17 Rev 7/2009

State

Registrar

APR 0 5 2011

Please Type or Print in Black Indelible Ink 57201r, WI Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ 28 201 2020 M JOHNSON ERBERT 03 Medical acility Name (if not institution, give street and number) City, Town, or Location of Death 4c. County of Death **Examiner** MERCY MEDICAL CENTER BALTIMORE BALTIMORE CITY Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Age (In vrs. last birthday) **Funeral** 1**X**M 2□ F Days Hours Min. 03 Ol 3 Months 302 325703 Director Usual Residence of Deceden 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director items 23a or 28a-f s ner must be notified 1 Yes 2 No Baltimore MD NA 10f. Zip Code 10e Street and Number 10a. Citizen of What Country? Funeral 124 West Franklin Street #509 21207 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Bace - American Indian. ıral", or iten I Examiner ı Was Decedent Evel Armed Forces?

1 XYes 2 No If Yes, Give Year or Dates. Black, White, etc. ρ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 within 72 hours after 1 ☐ Yes 2 😾 No Specify: Specify: Black "natural" Completed 3 Widowed 4 Divorced Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hyglene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meany once. Elementary/Seconday (0-12) College (1-4 or 5+) Baltimore City 12th grade Job Placement Specialist 6yrs Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ida Miller Andrew Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 43068 Kai Landis-Daughter 8114 Reynoldswood Dr., Reynoldsburg, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) On-Site 4/2/2011 Baltimore of runeral Service Licensee 22. Name and Address of Facility March F/H West 4300 Wabash Av Signatu Ave Baltimore, Md 33a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Physician/ YSRHYTHMIA disease or condition resulting in death) Medical Examiner DEONARY ARTER Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed ng physician and as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 the attending IF FEMALE nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ___ in the past 12 months? for Month Year Day Pregnant at time of death page 2 should be detached 9 Unknown g I Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 Yes 2 No funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: Other: 1 🗌 Yes ER/Outpatient 3 DOA 4 Nursing Home |은 1 Inpatient 2 28b. Time of 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28d. Describe how injury occurred Certificate: After Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation within 24 hours after death To the Funeral Director: the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide completed filled in by determined City or Town, State, Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature 29d. Date signed (Month, Day, Year) LITENDING HYSICIAN 1673 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1105 PACA STEET STE 200 BALTIMORE MD 21201 JEN JAHN I AWNER APR 0 5 2011 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#19a, perFH, G914, 4/5/2011, WS
State of Maryland / Department of Health and Mental Hygiene? for State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 201 Physician/ 11:38AM ones Hor. Medical on, give street and number) 4b. City, Town, or Location of Death County of Death Examiner Himore limonium aris If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 710 av 1929 Min. 8 Months Hours 1 M 2 X F MD Director items 23a or 28a-f show ner must be notified at 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at once. 10b. County 10d. Inside City Limits 10a. State Funeral Director Baltimore 1 Yes 2 No 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21201 USA Blassom nerry 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No ģ 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) conday (0-12) College (1-4 or 5+) todia Be fier's Name (First, Middle, Last) Baltimore, Maryland ပ homas Johnson Informant's Name/Relationship (Type, Print) herry Blossom Henry Jones (Husband) Method of Disposition 1 Burial 2 Cremation 3 Removal from State cemetery, cremato 4 ☐ Donation 5 ☐ Other (Specify) au re of Funeral Service Lice 23a. Part 1. Enter to disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ DEMENTIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or linjury the burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician I for use as the burial Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d, Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 X No been signed by the atte should be detached for Month Day Year Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has | autopsy perform r this certificate haral director, page 1 Yes 2 No Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 N Other (Specify) HOSPICE 2 X No မ 1 Inpatient 2 ER/Outpatient 3 DOA funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 Yes 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After completed filled in by the funer 1 X Natural injury 5 Pending Accident 2 🗌 No Investigation 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JACKIE JONES, CRNP 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year, 32. Registrar's Signature State APR 0 5 2011 Registrar

a.m.

11:38

2011

APRIL

LILLIE JONES

11-02545 Floyd Keyton		Please Type or Print in Black Indelible Ink. Ensure All Cop State of Maryland / Department of Health and Mental Certificate of Death	Hygier	ie Re	201	1 10781
Physician Medical Examine	er	1. Decedent's Name (First, Middle, Last) Floyd M. Keyton 4a. Facilify Name (if not institution, give street and number) 4b. City, Town, or Location of Decedent's Name (if not institution)	Mor Apri	of Death th 13, 20	Day Year	3. Time of Death 0435 hrs
8		12720 Puluski Highway 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24		te of Rint	Baltimore C	County
Funeral Director		274-74-9225 1XM 2 F 39 Yrs. Months Days Hours N			0,1971 F°	
land -f show any once.	5	Usual Residence of Decedent 10a. State				10d. Inside City Limits 1 Yes 2 X No
th the Maryland 23a or 28a-f sho notified at once.	Director	10e. Street and Number 11345 Pulaski Highway 21162		10	Og. Citizen of What C USA	Country?
er death wi , ur items	Fune	11. Marital Status 1 X Never Married 1 Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 3 Widowed 4 Divorced 1 Yes, Give Year 1 Yes 2 X No specify:			White, et	merican Indian, Black, c. White
36 nin 72 hours a han "natura dical Examiga	Completed by	15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) College (1-4 or 5+) Manufacter		e	16b. Kind of Busine Silver	·
21215-0036 build be filed within 7 Menal Hygiene. marked uther than c event, the Medica	å å	17. Father's Name (First, Middle, Last) Floyd Mayes Patri			laiden Surname)	
MD 21 d 2 should Ith and Me n 27 is ma	-[19a. Informant's Name/Relationship (Type, Print) Floyd Mayes /father 19b. Mailing Address (Street and Number of 11345 Pulaski His	ighwa		hite Ma	rsh MD 211
Baltimore, MD permit. Pages I and 2 shr Department of Health and Department of Health and Important: If item 27 is injury or other traumati		4 / Denation 5 Other Specify:	Date 4 / 4 /	11	20c. Location - City Baltime	
	- 1	21. Sign are ure of F ne at Service Licens 22. Name and Address of Facility Connelly Fur 23. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac				alto. MD ssex 21221
Physician /Medical Examiner		Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, surfi as cardiac failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) a. Multiple Injuries Due to (or as a consequence of):	c or respira	tory arre	st, shock, or heart	Approximate Interval Between Onset and Death
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eath c eatten for us		IF FEMALE: 33b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify) 9 Unknown			23d. Date of delive Month	very Day Year
S, P.O. B juires that the density the did be detached	ed by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	1	_	2 ✓ No 3 ☐ F	to the cause of death? Probably 4 Unknown

Division of Vital Records, P.O. Box 68760,	To the Hospital or Attending Physician: The law requires that the death certificate be executed	urs after death.	To the Funeral Director: After this certificate has been signed by the attending physician and	completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	
Divi	To the Hospital or /	within 24 hours after death.	To the Funeral Dire	completely filled in t	

certificate has been s'ector, page 2 should	Be Completed	25. Was case referred to medical examiner?	Hospital 4 Inspired 2 ED/Outputient 2	24a. Was an autopsy findings available prior to completion of cause of death? 1 Ves 2 No 1 Ves 2 No					
within 24 hours after death. To the Funeral Director: After this certificate has been completely filled in by the funeral director, page 2 should	ertification: To	1 Yes 2 No 27. Manner of Death 1 Natural 5 Pending 2 Accident Investigat 3 Suicide 6 Could not determine	28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28c. Injury at Work? 1 Yes 2 X No 28e. Place of Injury - At home, farm, street, factory, office building, etc.		and Home 5 Residence 6 ✓ Other: Scene 28d. Describe how injury occurred subject struck by train 28f. Location (Street and Number or Rural Route Number, City or Town, State) rear of 12320 Pulaski Hgwy. Balto. Co, Md.				
	Medical Ce	29a. Certifier 1 CertifyIng Physic	clan; To the loss of my knowledge, death occurred a er.On the lossis of examination and/or investigation, in and manner stated.	t the time, date and place, an	d due to the cause(s) and manner as stated.				
		- //		O.C.M.E.	April 3, 2011				
OME		30. Name and address of person who completed cause of death (Item 23a) Mary G. Ripple MD Deputy Chief Medical Examiner 111 Penn Street, Baltimore, MD 21201							
S Regis			32. Registrer's Signifiure						

MD 21162

OCME

			Please Type or Pri					10702
			For State Of Ma	•	Certificate of D	lealth and Mental Hy Death	Reg. No.	10/02
	Physicia Medic		1. Decedent's Name (First, Middle, Last) Mayore Kebs			2. Date of D Month	Day Year	3. Time of Death
	Examir		4a. Facility Name (Prot institution, give street and number) Oak Crest Care Center		4b. City, Town, or Parkvi		4c. County of Dea	
0	Funeral Director			e (In yrs. last birtho	day) If Under 1 Year Months Days	If Under 24 Hrs. 8. Date of Bi Hours Min. (Month, D	g. Bi ay, Year) 1912 Mar	rthplace (State or Foreign ountry) 'Yland
100	land show d at	tor	Usual Residence of Decedent 10a. State 10b. County Baltimore	10c. City, Town o	or Location			10d. Inside City Limits
3/31/11	er death with the Maryland or items 23a or 28a-f show niner must be notified at	Direc	10e. Street and Number	- Tark	10f. Zip Code		10g. Citizen of What C	1 🗆 Yes 2 💆 No ountry?
3/3,	ath with ems 23a must b	unera	8820 Walther Boulevard #4324 11. Marital Status 12. Was Decedent E	ver in LLS	212		USA 14. Race - Am	origan Indian
9036	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at <u>once.</u>	Completed by Funeral Director	1 ☐ Never Married 2 ☐ Married 1 ☐ Never Married 2 ☐ Married 1 ☐ ☐ Sez 2 2 3	No	If Yes, specify Cubar	spanic Origin? (Specify Yes or No n, Mexican, Puerto Rican, etc.) Specify:	Black, Whi	te, etc.
Maryland 21215-0036	iin 72 ho e. han "na'	omple	15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5	+) ((Decedent's Usual Occupa Give kind of work done di fe. DO NOT use retired)	ition uring most of working	16b. Kind of Business	Industry
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1217 ryland	ould be find marked matic ev	To.	Edgar Holmes			Jenny Lewis		
, Ma	nd 2 sho ealth an m 27 is i		19a. Informant's Name/Relationship (Type, Print) Elaine Gugerty/Daughter	2:	314 Spring Lake	nd Number or Rural Route Numb e Drive Timonium M a		ip Code)
ارداء الم	Page 1 a nent of H ant: If ite ıry or ott		20a. Method of Disposition 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)	cemetery,	Disposition (Name of crematory or other place S of Faith	Date 4/4/11	20c. Location - City o	
Krebs, Baltimoré	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee		22. Name and Address Leonard J. Ruc 5305 Harford	s of Facility K, Inc. Road Baltimore Maryl	and 21214	
			23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line Immediate Cause (Final	the death. Do not	t enter the mode of dying	, such as cardiac or respiratory a		Approximate Interval Between Onset and Death
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		iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	consequence of)	:			
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09L89	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	edical	d					
05 ⁻		Completed by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Live Birth 9 □ Unknown 9 □ Unknown	2 🗌 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)	/	23d. Date of do Month	elivery Day Year
214- , P.O. I			Part II. Other significant conditions contributing to death by	ut not resulting in			tobacco use contribute t	
ords			atul h	b		24a. Was	s an 24b. Were a	Probably 4 Unknown utopsy findings available
Rec	ı: The lar icate har r, page 2		25. Was case referred to medical			perfi	formed? death?	completion of cause of
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19/2 ion of	ding Ph th. After th funeral		27. Manner of Death 1 ☑ Natural 5 ☑ Pending 2 ☑ Accident Investigation	y 28b. Tin (Year) inju	ury work?		how injury occurred	
S	or Atter after dea Director d in by the	Certificate:	2 Cuipida 6 Could not be	ry - At home, farm . <i>(Specify)</i>	n, street, factory, office		(Street and Number or Rown, State)	ural Route Number,
0/04,	e Hospita 124 hours 9 Funeral leted filled	Medical	29a. Certifier (Check only one) 3 Certifying Physician: To the best of expension of expension of the best of expension of expension of the best of expension of exp	camination and/or i	investigation, in my opinior	n, death occurred at the time, date	and place, and due to the	cause(s) and manner stated.
	To the withir comp		29b. Signatule and title of contifer	X	29c. Leense	number 4242_	29d. Date signed (Mon	
10			30. Name and address of person who completed cause of de	eath (fem 23a) (Ty	Sto Wal	the Glad 1	lankrite 1	Md 21234
	Sta Registra	te		r's Signature		•		
DHI	MH 17 Rev 7/20	_	The second secon					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. For State Registrar State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 30, 2011 Kehs Year Walter 7:45 P. Medical 4a. Facility Name (if not institution, give street and number) County of Death Baltimore **Examiner** 4b. City, Town, or Location of Death Parkville 2806 Glavin Way Apt C Social Security Number If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country)
 M 8 Date of Birth 7. Age (In yrs. last birthday) **Funeral** Days 1 👿 M 2 🗆 F Hours 06/18/1918 215-01-2695 **Director** Yrs Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at **Funeral Director** 1 🗆 Yes 2 🛣 No Baltimore MD Baltimore 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 23a U.S.A. 21234 2806 Glavin Way Apt. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. by 1 Never Married 2 Married "natural", or 2 🗌 No 1 X Yes If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify Completed 3 X Widowed 4 Divorced Year or Dates. WWII White Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) filed within Construction Electrician 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Sophia Kehs Strasheim Jackson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 1704 Farmshire St. Jarrettsville, MD 21084 Gary Kehs, Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 04/04/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Gardens Of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility. 1 Economic J. Ruck, Thic. 5305 Harford Road Baltimore Maryland 21214 laandua 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician CONGESTIVE HOMET FAMILY disease or condition resulting in death) DAMS Medical Due to (or as a consequence of **Examiner** MIMM NEGULATION TEMS Sequentially list conditions, Examiner Due to (or as a concequence of): AND if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Hospital or Attending Physician: The law requires that the death certificate be executed 134 PUNTENSION 1 cms MIMUNMY Due to (or as a consequence of) resulting in death) Last Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Pregnant at time of death 2 No 9 Unknown Unknown P.O. by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, RENM WSUFFICIENCY 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has e 2 s autopsy performe ☐ Yes 2☐ No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Natural 5 \square Pending injury 1 ☐ Yes 2 ☐ No Director; / Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as state only one) re and title of certifier 29d. Date signed (Month, Day, Year) month 31,2011 D15135 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5601 LOLD NAWN SUD, BARMON, MO PEMOUNE SWIT MD

Registrar

DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year,

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. Nor 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Year APRIL HYLLIS KRAUSHAR 11:17 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death HARBOR HOSPITAL BALTIMORE Social Security Number If Under 1 Year | If Under 24 Hrs 8. Date of Birth 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 □ M 2 🕅 F Months Days Hours July 7, 1935 Director 219-32-3555 75 Usual Residence of Decedent 28a-f show 10a. State 10b. County Examiner must be notified at 10c. City. Town or Location 10d. Inside City Limits Director MD Baltimore Arbutus 1 Tes 2 X No 23a or 2 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1321 Maple Avenue 21227 USA or items 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 XNo Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: White If Yes, Give "natural", 3 Divorced Completed Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry 2 should be filed within 72 in and Mental Hygiene.
7 is marked other than "r (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 12 Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Rex Welch Mary Robinson of Health and Nitem 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anton D. Kraushar-Husband 1321 Maple Avenue Arbutus Maryland 21227 Page 1 and 2 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of 1
Importact: If ite
any icjury or ot
once. Date 1 Burial 2 Cremation 3 Removal from State Apr. 8, 2011 Sykesville Maryland 4 Donation 5 Other (Specify) Lakeview Mem.Park 22. Name and Address of Facility Am rose Funeral Home Inc. 21. Sign of Full al Service Licenses 1328 Sulphur Spring Road Arbutus Maryland 21227 alle 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line. Immediate Cause (Final SEPSIS Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner PNEUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed and use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No ģ Day Pregnant at time of death 5 Other (specify) Month Year 4 ☐ Pregnant 9 ☐ Unknown 1 ☐ Yes ∠ ≠ 9 ☐ Unknown us been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by RENAL DISEASE ON HEMODIALYSIS 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy performed' 1 Tes 25. Was case referred to medical examiner?

1 Yes 2 No funeral director. Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: To ER/Outpatient 3 DOA Inpatient 2 🗆 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Natural 5 Pending iniury work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation 24 hours after death Funeral Director: 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one) 29b. Signature and title of certifier 29c. License numbe arma RES 000 APRIL 4,2011

State Registrar

OHMH 17 Rev 7/2009

SOUTH HANOVER STREET BALTIMORE MD 21225

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

001

32. Registrar's Signature

SUNITA SHARMA

31. Date filed (Month, Day, Year) **APR** 0 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ P^{M} Frederick Kaline, Jr. April 2011 George Medical Examiner 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fairfield Nursing Rehab. Center Crownsville Anne Arundel Social Security Number If Under 1 Year If Under '. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🕅 M 2 🗆 Days (Month, Day, Ye Months Hours Maryland Director 1928 220-22-5369 82 June Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10a, State 10b. Count within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Anne Arundel Pasadena 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 871 Deering Road 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 M Yes 2 75/1951

If Yes, Give 2/5/1953

Year or Dates.1/9/1953 Black, White, etc. <u>م</u> 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 Specify White 1 ☐ Yes 2 X No Specify: "natural", 3 Widowed 4 Divorced Completed traumatic event, the Medical Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) 2 should be filed within 72 h h and Mental Hygiene. 7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) Inspection Supervisor Westinghouse Elec. Corp Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည George Frederick Kaline, Sr. Elsie Scheckells I and 2 should be If Health and Me Item 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Carole M. Kaline wife 871 Deering Road Pasadena, MD item 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite Date 9 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Injury (4 Donation 5 Other (Specify) MD Veterans Cemetery Crownsville, MD 21 April ture of Funeral Service II censes 22. Name and Address of Facility Singleton Funeral & Cremation any M00918 Svs. 1 2nd Avenue, S.W. Glen Burnie, MD 21061 NONTE 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due ty (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consician and burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: . If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown nse 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Po Day Month Year signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has performed After this certificate 2 NO 1 🗌 Yes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be Hospital: Other: 1 Tyes 2 **X**No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death. To the Funeral Director: A Accident Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifie Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nyrse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifie 29c. License number 12) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print SW ree

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene ? 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death A pri Physician/ Kinsey 2.21 PM 1 ARL 2011 Medical Facility Name (if not institution, give street and number) Anne Arunde Town, or Location of Death Balkimore Wishington Medial Examiner Glan Burnia If Under 1 Year | If Under 24 Hrs 5. Social Security Number Sex 1X M 2 F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Hours Sept. 2I Country) 220-09-8820 91 Director ,1919 OH Usual Residence of Decedent 27 is marked other than "natural", or items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Director 1 🗌 Yes 2 😾 No Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 41 Chester Circle 21060 U.S.A. Hygiene. other than "natural", or items 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Armed Forces?

1X Yes 2 No Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. White If Yes, Give 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Machinest Railroad should be filed with and Mental Hygien 7 is marked other the 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Oran Lee Kinsey Elizabeth Lenora Helms permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Mr John Kinsey /Son 803 Rosewood Road Severn Maryland 21144 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State April 8, 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Meadowridge Mem. Park 2011 Elkridge,MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ 141 PINGON disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** RUH Loke MUMONIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events southing in dooth). Examine UNKHOWN sician and burial-transit Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical certificate be Division of Vital Records, P.O. Box 68760 as the l IF FEMALE: yes, outcome of pregnancy use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy for in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 1. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 1 Tyes To the Hospital or Attending Physician: The law require within 24 hours after death.

To the Funeral Director: After this certificate has been si completed filled in by the funeral director, page 2 should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician: The law 1 24 hours after death. Funeral Director: After this certificate has b yes 2 1 🗌 Yes 2 🗆 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No ၉ Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 Yes 2 No 2 Accider
3 Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one Certifying Nurs Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature a 29d. Date signed (Month, Day, Year) D 0022483 2,2011 mpleted cause of death (Item 23a) (Type, Print Dr. Glen Burne, MD 2106 Hospital 305 OBS MO State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ Mar 28, 2011 10:00 AM Mary Carol Kelly Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Howard Jessup 8413 Oak Meade Way 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year) Oct 23, 1941 Months Days Hours Min. Country) 1 M 2 X F 25 MD 69 Director Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must <u>be notified at</u> 10d. Inside City Limits 10a, State 10b. County 10c. City, Town or Location with the Maryland Director Jessup MD Howard 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20794 U.S.A. 8413 Oak Meade Way should be filed within 72 hours after death v and Mental Hygiene. is marked other than "natural", or items. Was Decedent of Hispanic Ongin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates. ş 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) **Howard County Public** Building Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ Rose Mary Young Charles Ridgley permit. Page 1 and 2 should be Department of Health and Men-Important: If item 27 is marke any injury or other traumatic & 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Shari Logan Daughter 9026 Early April Way Ellicott City, MD 21043 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Apr 01, 2011 Ellicott City, MD St. John's Cemetery 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Slack Funeral Home, P.A 3871 Old Columbia Pike Ellicott City, MD 21043 23a. Part Penter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last sician and burial-trans Due to (or as a consequence of) attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be to thours after death.

Funeral Director: After this certificate has been signed by the attending physicia Box 68760 the as IF FEMALE nse 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 🗆 Fetal death 3 Ectopic pregnancy for in the past 12 months?

1 Yes 2 No Day 5 Other (specify) Pregnant at time of death signed by the a 9 Unknow Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 2 200 3 ☐ Probably 4 ☐ Unknown 1 Tyes Completed ns certificate has been s director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ည 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) 5 \square Pending work 1 ☐ Yes 2 ☐ No М 2 Accident
3 Suicide Investigation completed filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined 24 hours Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check To the within 2 only one) 3 [Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d, Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ST ATON

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

APR 0 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death 3. Time of Death Physician/ Month Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death Examiner Randallstown Baltimore Seasons Hospice Northwest Hospit If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 T Director 219-26-3963 70 12-24-1940 New York Usual Residence of Decedent or 28a-f show 10a. State 10b. County ral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 🕅 No Maryland Anne Arundel Curtis Bay 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1617 Spruce Street filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Force Black, White, etc. ģ 1 Never Married 2X Married 1 ☐ Yes 2 💢 No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: Specify: WHITE "natural" Completed 3 Widowed 4 Divorced Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) 2 vears Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ George Gabelle Gladys Meier 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Anna Kovacs - DAUGHTER 5423 Wasena Avenue, Baltimore, MD 21225 20a. Method of Disposition
1 ☐ Burial 2 ⚠ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory INC 04-04-2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland 299 Frederick Road, Baltimore, Maryland 21228 Patrik FLeming Part 1. Enter the disease, or complications that cau shock, or heart failure. List only one cause on each ed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition resulting in death) Medical o (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of) resulting in death) Last physician a the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Pregnant at time of death Month Day Year s been signed by the should be detached g Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 1 Yes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has e 2 autopsy page performed Yes 2 death? this certificate Yes 1 Yes director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital 2 X No 1 Tyes Other: ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Spec within 24 hours after use...

To the Funeral Director: After the committee filled in by the funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate; 28c. Injury at 28d. Describe how injury occurred Natural Accident 5 Pendina work? Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifie ted cause of death (Item 23a) (7) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 4 Physician/ Day 3:00 PM Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 7750 Twin Oaks Road Anne Arundel Severn Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🕅 M 2 🗆 F (Month, Day, Year) 01-23-1937 Months Days Hours Maryland Director 213-32-4348 74 Usual Residence of Decedent or 28a-f show notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hyglene. ant: If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 X No Anne Arundel Severn 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? er than "natural", or items 23a or the Medical Examiner must be Funeral 7750 Twin Oaks Road 21144 United States Was Decedent of Hispanic Ongin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: Completed 3 X Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edward Willard Leary, Carrie Ruth Grase 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kathlyne Leary / Daughter-in-law 515 Pasture Brook Road Severn, Maryland 21144 other 20b. Place of Disposition (Name of cemetery, crematory or other place)
Epiphany
Episcopal Cemetery 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 04-07-2011 Odenton, Maryland 21. Signature 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P 1411 Annapolis Road Odenton, Maryland Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest.
 or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final retion ATTECK .Physician/ heart disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine attending physician and for use as the burial-transit law requires that the death certificate be executed that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 5 Other (specify) Day Pregnant at time of death 1 ☐ Yes 2 ☐ Unknown been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Ninknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed this certificate has Hospital or Attending Physician; The 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 1 Tyes 2 No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred After 1 Alatural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu 2 Accident
3 Suicide
4 Homicide 1 Tes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 🛰 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0005025 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

101

State Registrar

Bahador Momeni, M.D., 8601 Veterans Highway, Ste 211 Millersville, Maryland 21108
31. Date filed (Month, Day, Year)
32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret S. Ludwig April 3, 2011 9:05 P. M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Timonium** 4c. County of Death Baltimore Examiner Stella Maris Social Security Number If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthdav Funeral 1 🗆 M 2 🙀 F Month, Day, Year) Months Days Hours 214-30-5823 77 Maryland **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director Glen Arm Maryland Baltimore 1 Tes 2 X No 10f. Zip Code 21057 10e. Street and Number 10g. Citizen of What Country? 12910 Kanes Road Funeral USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian. Armed Forces?

1 Yes 2 XXNo Black, White, etc ģ 1 Never Married 2 Married 21215-0036 1 Yes 2 X No Specify. 3 Widowed 4 Divorced White Completed Year or Dates the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) filed within 72 tal Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Law Office Bookkeeper uth and Mental Hygie 27 is marked other r traumatic event, the Be Maryland 18. Mother's Name (First, Middle, Maiden Surname)
Katherine Sterling 17. Father's Name (First, Middle, Last) permit, Page 1 and 2 should be fill Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve Frederick Scharnagle 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 406 West Pennsylvania Avenue Towson Maryland 21204 19a. Informant's Name/Relationship (Type, Print) Jeffrey Foreman/ Attorney Baltimore, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Parkwood Cemetery ₩ Burial 2 Cremation 3 Removal from State 4/5/11 Baltimore Maryland 4 Donation 5 Other (Specify) ²² Name and Address of Facilitinc 5305 Harford Road Baltimore Maryland 21214 Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician END STAGE disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit that the death certificate be executed Due to (or as a consequence of) resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death the be detached þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Records, 1 🗌 Yes Completed completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) of Vital Be examiner? MARGARET 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending work? 1 ☐ Yes Division 2 🗌 No Accident Investigation 24 hours after deat Funeral Director: 6 Could not be ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one within 2 To the 29b. Signature and who completed cause of death (Item 23a) (Type, Print) 2300 31. Date filed (Month, Day, Year, 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Dr,	To the Hospital or Attending Physician: The law requires that the death certification is the Hospital or Attending Physician.	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	(Check 2 l		Physician: To the best of maniner: On the basis of exa Nurse Practioner: To the b	amination and	d/or investiga	tion, in my opini	on, death or	ccurred at	the time, date a	and place	e, and due	to the cau	se(s) and mar	nner stated.
	To ti	To t		29b. Signature and ti	itle of certifier	touling	Ollys	TICKUM	29c. Licens	e number	56:	2_	29d. Da	ote signed	(Month, E	ay, Year)	11
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 8,18 per fh g914 4-12-11 yt State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 T 1:40 A M Evelvn Moan Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore 11 Fleming Drive Dundalk Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Feb 3, 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) **Funeral** Days Hours Min. Maryland 1 □ M 2 🗓 F 213-86-8417 Yrs 81 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10h County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at anoie. 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🎇 No Baltimore Dunda1k Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21222 USA 11 Fleming Drive 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Armed Forces? þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 XNo Specify: Specify: Black Completed 3 X Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Home Maker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)
Otelia P. Ferguson ဂ္ OtheIia <u>Earl H. Pat</u>terson -Ferguson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Dundalk, Maryland 21222 Rita D. Randolph, Daughter 1908 Codd Avenue 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial ② Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 04/05/11 Metro Crematory Inc. Baltimore, Maryland 21. Signature of Funeral Service License ^{22. Name and Address of Facility} Cremation Society Of Maryland, Inc. 299 Frederick Road Baltimore, Maryland 21228 Thomas Gregor homas 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Liner Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a consequence of). attending physician and for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Month Day Year Yes 2 No signed by the a d be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacce use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed After this certificate 2 🗌 No 1 🗌 Yes Yes completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 No Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မှ 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending Natural Natural 1 Yes 2 No Investigation Could not be Accident Director: Suicide 6 🗌 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide within 24 hours a Medical Certifying hysician: To the be 29a. Certifier of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. aminer: On the ba nd/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. of examination Medica (Check Certif **Nurse Practione** the best of m nowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of noleted cause of death d address of a Item 23a) (Type, Print) Pau 101

State

Registrar

31. Date fi

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32. Registrar's Sig

State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death DRA Physician/ ANE MAY ZUI 0321 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Mandrin House Harwood If Under 1 Year If Under 24 Hrs. Social Security Numbe 6 Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** ^{Year)} 914 Months Days Min. (Month, Day, May 18 1 🗆 M 2 🔽 F Hours North Carolina Director 172-22-4017 96 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 K No Maryland Prince George's 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral United States 3513 Saville Lane 72 hours after death 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian. 11. Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. þ 1 Never Married 2 Married Ves 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: "natural" 3 Widowed 4 Divorced Specify African American Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Seamstress Clothing 6 injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, permit. Page 1 and 2 should be file Department of Health and Mental H Important: If item 27 is marked any injury or مدد ည Noble Russell Ida Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janice Kennedy-Allen/Daughter 3513 Saville Ln Bowie, MD 20721 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Woodbine, Maryland Journey Crematory 4/5/2011 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21. Signature of Funeral Service Licer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear dailure. List only one cause on each line. Approximate Interval Between M DW 11+5 Immediate Cause (Final CANCER ZNOOMETRIAL Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last physician a sthe burial-t Physician/Medical Box 68760 as IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown use 23b. Was decedent pregnant 23d. Date of delivery 3 🗆 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Por Day 5 Other (specify) Month Year signed by the ar P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, To the Hospital or Attending Physician: The law requires within 24 hours after death.
To the Funeral Director: After this certificate has been sign completed filled in by the funeral director, page 2 should be 1 🗆 Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Division of Vital 25. Was case referred to medica 26. Place of Death (Check only one, examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence +OSPICE 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death House 28c. Injury at 28d. Describe how injury occurred Certificate; 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the pest of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number Name and address of person who completed cause of death (Item 23a) (Type Print)

1.1. HAR J.L. FENTH WM 44(1) EFENSE HWY 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month March Physician/ 2011 2011 A M 9:58 Adrianus Johannes Meijer Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Woodbine Howard 3561 Hipsley Mill Road Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🏻 M 2 🗆 F Months Days Hours Min. (Month, Day, Yea Netherlands 1940 **Director** May 577-66-2741 70 Usual Residence of Decedent ıral", or items 23a or 28a-f show I Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location death with the Maryland Director 1 Yes 2 X No Maryland Howard Woodbine 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral United States 3561 Hipsley Mill Road 21797 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 X Married within 72 hours after Maryland 21215-0036 1 ☐ Yes 2 K No Specify: If Yes, Give Year or Dates. Specify: "natural", Completed 3 Divorced 4 Divorced White e 1 and 2 should be filed within 72 hours of Health and Mental Hygiene. If item 27 is marked other than "natur or other traumatic event, the Medical. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Data Processing Manager Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Johan Hendrikus Schreutelkamp Hendrika Woerst 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3561 Hipsley Mill Rd. Woodbine, MD 21797 Avis A. Meijer / Wife timore, 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State permit. Page 1 Department of Important: If ii any injury or or cemetery, crematory or other place) 1 Durial 2 X Cremation 3 Removal from State Final Journey Crematory 4/1/2011 4 ☐ Donation 5 ☐ Other (Specify) Woodbine, Maryland 22. Name and Address of Facility Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final metastatic ideno corcum Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, If any leading to immediate cause. Enter Underlying or Attending Physician: The law requires that the death certificate be executed Exam Cause (Disease or linjury that initiated events attending physician and for use as the burial-tran Due to (or as a donsequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy
5 ☐ Other (specify) ____ in the past 12 months? Month Day Year Pregnant at time of death Unknown 2 🗆 No sate has been signed by the page 2 should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 Robably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed After this certificate 1 ☐ Yes 2 🛣 N 1 ☐ Yes 2 🔀 No after death.

Director: After this certific 25. Was case referred to medical 26. Place of Death (Check only one) Be 2 No Other: မ 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 1 Natural 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 🗌 Yes 2 🗌 No 2 Accident
3 Suicide Investigation Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Limit Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I only one) Signature and title of certifier

State

Registrar
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30, Name and address of person who completed cause of death (Item 23a) (Type, Print)

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#IperPHYS, G914, 4/19/2011, WS
State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) Larena K. Mullinix 2. Date of Death 3. Time of Death Physician/ March 3 Pay 2011 3:00 A Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Golden Living Center Westminster 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** (Month, Day, Year) 1 M 2 🔀 F Months Days Hours Min. 1927 Maryland Director 214-24-7710 Sept. Usual Residence of Decedent ıral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director MD Carrol1 Westminster 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 225 Frock Drive Apt 148 21157 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 11. Marital Status 14. Race - American Indian, Black White etc. þ 1 Never Married 2 Married Yes 2 X No Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 🔀 No Specify: or than "natural", the Medical Exa Specify: Completed 3 Widowed 4 Divorced White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Should be file and Mental E ည Department of Health and Ment, Important: If item 27 is marrer any injury or com-Keturah Glime James Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 225 Frock Drive Apt 148; Westminster, MD 21157 Husband Alvin Mullinix Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State Loudon Park Cemetery 4/4/2011 Baltimore, MD 4 Donation 5 Other (Specify) 2. Name and Address of FacilitySterling Ashton Schwab Witzke Tuneral Home of Catonsville, Inc. 630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Funeral Service Lic Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set an Death Immediate Cause (Final ·Physician/ mome disease or condition resulting in death) Medical ue to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as a consequence of relies Exami physician and the burial-transit Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Pregnant at time of death 1 Yes 2 9 Unknown signed by the a g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autope performed: certificate has page 1 Yes 2 No ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2 No Other: 1 Yes 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending injury 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: At completed filled in by the fu Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check To the 1 within 2 To the 1 only one 29b. Signa 29c. License number 29d. Date signed nd address of person who completed cause of death (Item 23a) (Type, Print) State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Vear **Physician** 1203 PM Arthur Joseph McColgan MARCH 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 8. Date of Birth (Month, Day, Sept. 28, 9. Birthplace (State or Foreign Country) Maryland Social Security Number 7. Age (In vrs. last birthday) **Funeral** Months Days Hours 1 X M 2 □ F 218-22-8827 82 1928 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, it is Medical Examinations to be promitted at 10d. Inside City Limits 10c. City, Town or Location 10b. County 1 ☐ Yes 2 No Directo MD Baltimore Catonsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 509 Crosby Road 21228 USA by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status 1KYes 2 No 1 Never Married 2 Married 3altimore, Maryland 21215-0036 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 🛣 No Specify: 3 Widowed 4 Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Government Accounting Manager 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be J. Foley McColgan Anna Marie Ackerman ပ္ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) Jean Hall Sister 1427 Pleasant Valley Drive; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4/4/2011 Woodlawn, Maryland 22. Name and Address of Facility Sterling Ashton Schwab Witzke Funeral Home of Catonsville, Inc. 1630 Edmondson Avenue; Catonsville, MD 21228 21. Signature of Ineral Service License Approximate Interval Between Onset and Death 23a. Part 1. Enter the diser le, or complic flons that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 0 CAT2 01A MINUTE disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) □Yes 2□No 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 9 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an has autonsy 1 □ Yes 2 No or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 2 ER/Outpatient 3 DOA 1 Inpatient Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Division Injury 1 ⊒ Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide Vithin 24 hours are
To the Funeral Dir 29a. Certifie Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

12+1

of Vital

State Registrar

mani lu

JONATHAN

31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

ONQU

900

AVENUE BALTIMORE

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death March 31. Year Physician/ 2011 7:00 A. M Louise Baker Macomber Medical 4b. City, Town, or Location of Death 4c. County of Death 4a, Facility Name (if not institution, give street and number) **Examiner** Baltimore Parkville 2326 Foster Avenue 8. Date of Birth (Month, Day, Year) March 4, 1920 9. Birthplace (State or Foreign Country)
Texas 1 Year If Under 24 Hrs. Social Security Number 7. Age (In vrs. last birthday) **Funeral** Days Months Hours Min. 1 - M 2 X F 91 Director 465-05-4508 Usual Residence of Decedent 10d. Inside City Limits 23a or 28a-f shov 10c. City, Town or Location and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Iem 27 is marked other than "natural", or items 23a or 28a-s show 10a. State 10b. County item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, the Medical Examiner must be notified at Director Parkville Maryland Baltimore 1 Yes 2 X No 10g. Citizen of What Country? 10e. Street and Number 10f, Zip Code USA Funeral 2326 Foster Avenue 21234 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14 Bace - American Indian. 11, Marital Status Black, White, etc. ☐ Yes 2 🔀 No Yes, Give 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 🕅 No Specify: White 3 X Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a, Decedent's Usual Occupation 16b, Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Office Administrator Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edith L. Thomson Will W. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1075 Raver Lane Glen Rock Pennsylvania 17327 Karen Hefner/Daughter Department of Healt Important: If item 2 any injury or other 1 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Page 1 1 X Burial 2 Cremation 3 Removal from State San Antonio Burial Park 4/4/11 San Antonio Texas 4 ☐ Donation 5 ☐ Other (Specify) ²²LName and Address River River Inc. 5305 Harford Road Baltimore Maryland 21214 21. Si natura of Fur eral Service License 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between On et and Death Immediate Cause (Final METASTATICBLADOER CANCER Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months? Month 5 Other (specify) Pregnant at time of death Unknown 9 Unknown as been signed by 2 should be detact 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy this certificate has page 2 1 No 1 Yes Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) funeral director, Hospital: Other: 2 No. 5 Residence 6 Other (Specify) မ 1 🗌 Yes 4 Nursing Home 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: s after death. work? injury 1 Natural 5 Pending Yes 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours. Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar Signat State Registrar

State of Maryland / Department of Health and Mental Hygiens Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 03 MINTON Bay 2011 Physician/ MARIE 12:45 PM JOAN Medical 4a. Facility Name (if not institution, give street and number). 4b. City, Town, or Location of Death 4c. County of Death Examiner Upper Chesapeake medical Bel Air, MD Harford If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** Hours 1 □ M 2 🔀 F May 1, 1946 Pennsylvania Director 64 164-36-8977 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Department of Health and Mental Hygiene. Important, or items 23a or 28a-f sho Important. If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic avent, the Medical Examiner must be notified at once. 1 🗆 Yes 2 🎽 No Harford Edgewood Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21040 3003 Ebbtide Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No Black, White, etc 23/29/2011 TOD 1245 þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: If Yes, Give Specify: White 3 Divorced 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Medical 5+ Director of Nursing Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ည Ursula Helen Radusky Stephen Bernard Speshok 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
3003 Ebbtide Drive, Edgewood, Maryland 21040 19a. Informant's Name/Relationship (Type, Print) William J. Minton / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Towson, Maryland Hilltop Service Corp 4-4-11 22. Name and Address of Facility McComas Funeral Home, P.A. Signature of Funeral Service License 1317 Cokesbury Road, Abingdon, Maryland 21009 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate
Interval Between
Onset and Death
2 days shock, or heart failure. List only one cause on each line Immediate Cause (Final Gastrointestinal Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Physician/Medical Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 5 Other (specify) Pregnant at time of death been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Sclerosis 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an MINDON SOAN MACOSHOODS autopsy After this certificate has performed; 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 No 1 Inpatient 2 FR/Outpatient 3 IDOA 28c. Injury at work? 1 🗌 Yes 2 🗎 No Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred Certificate: Natural iniury 5 Pending Accident Investigation within 24 hours after death To the Funeral Director: / Suicide 6 Could not be 3 ☐ Sulcide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier only one) 29b. Signature and title of certifie FC 1733799 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 500 Upper Chesapeake Dr. Bel Air, mo 2/014 Timothy Chizmar MD 0 5 2011 32. Registrar's Sigrature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND #8 PER FH G914 4/12/2011 JH

State of Maryland / Department of Health and Mental Hygiene 1 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day 2011 Year April 4 Physician/ 12:50 AM McCusker Peters Regina Medical 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** Baltimore Towson Gilchrist 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. 3ate of Birth 924 9. Birthplace (State or Foreign Security Number 6. Sex **Funeral** 1 □ M 2 🛣 F Days Hours Months Marvland 87 Director 218-16**-**0855 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at Director 1 🗆 Yes 2 🗓 No Towson Maryland Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e, Street and Number Funeral U.S.A. 21204 539 Piccadilly Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? 1 ☐ Yes 2 🔀 No Black, White, etc ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White If Yes, Give 3 🕅 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry Condominium 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 7: Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12 College (1-4 or 5+) Management Office Manager Be 17, Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Smith Marie Agnes Peters John Richard 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 303 Second Street York Springs, PA Joseph O. McCusker, III Son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Hilltop Service Corp. 4-7-2011 ☐ Donation 5 ☐ Other (Specify) Towson Maryland 22. Name and Address of Facility Ruck Towson Funeral Home, ture of Furth Inc. 21. Sign Towson, Maryland 21204 1050 York Road 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ LMENT CONT Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No Month Year n signed by the at Id be detached for 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 Yes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has ral director, page 2 autopsy performed 1 Yes 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{\text{Normal} Other} \) (Specify) Hospital hospice ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Medical Certificate: 24 hours after death. Funeral Director: After injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho

To the Fune

completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) the 29c. License number 2011

State Registrar W)

701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

. Date filed (Month, Day, Year) APR 0 5 2011 HANRS

32. Registrar's Signature

n-02110 Philip Warren McDa		or Print in Blac e of Maryland / b			A Mehtar	giê/067	II JH	10802
	1- For State Registrar		Certificate or	f Death			eg. No.	3. Time of Death
Physician/ Medical Examine	Decedent's Name (First, Middle,L Philip Warren					2. Date of Deat Month March 17,	Day Year 2011	2247 hrs
)	4a. Facility Name (if not institution, 224 W. Walnut Street	give street and number)		4b. City, Town, or Hagerstown	Location of Deat	h	4c. County of Deat Washington	h
Funeral Director	5. Social Security Numbetink 6.	Sex 7. Age (In	yrs. last birthday) 45 yrs	If Under 1 Yea Months Day		_	Forei	rthplace (State or unk gn puntry) Ohio
Aaryland 28s-f show any 1 at once. ector	Usual Residence of Decedent 10a. State 10b. County MD Washi	ngton 10c	City, Town or Locat	√n				10d. Inside City Limits 1 Yes 2 No
with the Maryland ss 23a or 28s-f sho re notified at once,		St.		10f. Zip Code 21740		1	0g. Citizen of What Cou USA	anu y ?
and 2 should be filed within 72 hours after death with the Mazyland feath and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumante event, the Medical Examiner must be notified at once To Be Completed by Funeral Director		12. Was Decedent Eve Armed Forces? 31 1 Yes 2 A	nk fy No	'es, specify Cubai		Rican, etc.)	White, etc. Specify: Whi	
6 n 72 hours an "naturical Exami	15. Decedent's Education (Specify	only highest grade complet	ed) 16a. Deceder during m	nt's Usual Occupa lost of working life	tion (Give kind of . DO NOT use ret	work done UTIK tired)	16b. Kind of Business	/industry
5-0036 ed within 72 hour. lygiene. other than "natu the Medical Exan Completed	Elementary/Secondary (0-12) 12 unk	College (1-4 or 5+)unk 0	De1	ivery			Pizza Pa	
MD 21215-0036 d 2 should be filed within 7 th and Mental Hygiene. n 27 is marked other than sumatic event, the Medical To Be Comple	Jerry McDan	iel			Dana	Reed	Maiden Surname) 'Uff	
MD 21 2 should h and Me 27 is ma matic ev	19a. Informant's Name/Relationship	nna McDaniel-	wife 900	W. Bal	timore S	t: Balti	more, MD 2	1 201
Baltimore, MD 2 permit. Pages I and 2 shou Department of Health and Important: If item 27 is I injury or other traumatic	20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State	20b. Place of Dispos crematory or ot		metery,	Date Date	201 201 201 200 Location - City o	Town, State
Baltir permit. P Departme Importar injury or	21. Signature of Funeral envice Lice	Wade Direc	Lor	555 W. B.	altimore	St; Bal	omy Board timore, MD	21201
Physician Medical ≛xaminer	23a. Part Enter the disease, or confailure List only one cause on Immediate Cause (Final disease or condition resulting in death)	mplications that caused the each line. Alcohol. a. Tramadol) Due to (or as a conseque	Intoxicati		such as cardiac iazepoxi	or respiratory arrode, Hydr	est, shock, or heart coxyzine,	Approximate Interval Between Onset and Death
red Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a conseque C. Due to (or as a conseque			_			
execui an and al - tra	X UNPENDED	d AMENDED 23a	,pt.II,27	,28a-f p	er me g9	14 4-6-1	ll vt	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicis completely filled in by the funeral director, page 2 should be detached for use as the burifical Certification: To Be Completed by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at time 9 Unknown	2 Fe	etal death 3 ther (Specify)	Ectopic pregn		23d. Date of delive Month	Day Year
, P.O. res that the signed by the detached by PP	Atherescleret		-		given in Part I.		bacco use contribute to	
Records, : The law requires fificate has been sign, r, page 2 should be Completed						1 Yes	sy prior to death?	utopsy findings available completion of cause of es 2 No
ital Redicion: The scertificate rector, page	examiner?	Hospital: 1 Inpatient	2 ER/Outpatient		of Death (Check		Residence 6 🗸 Othe	er Scene
n of Vi ding Physi a. After this funeral dif		28a. Date of Injury (Month, Day, Year)	28b. Time of		ry at Work?		how injury occurred	
ision Attendiar death. rector: A by the fu	1 Natural 5 Pending 2 Accident Investig	fd 3-17-1		45РЩ —	Yes 2 K No	unknow		
Division o septral or Attending hours after death. uneral Director: After the flue or filled in by the flue Certification:	3 Suicide 6 X Could r 4 Homicide determi	ot be	- At home, farm, stre de by sta			or Town, S	tate) 224 W. I	ural Route Number, City Walnut St. Ington Co, Mo
To the Hoswithin 24 ho To the Fun completely:		sician: To the best of my knowner:On the basis of examina	owledge, death occu ition and/or investiga	rred at the time, d tion, in my opinior	ate and place, and n, death occurred	d due to the caus at the time, date	e(s) and manner as sta and place, and due to t	ted. he cause(s)
To con	es a	and manner stated.		29c. Licens			29d. Date signed (Me	
	with.			O.C.	M.E.		March 18, 2011	
	30. Name and address of person what Ling Li, MD Assistant		(Item 23a) 111 Penn Stree	et, Baltimore,	MD 21201			
State Registra		32. Registrar's S	gnature					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Date of Death
 Month 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year **Physician** 201 Richard McCardell MARCI /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner 13A/ JES 8. Date of Birth (Month, Day, If Under 24 Hrs. Birthplace (State or Foreign
Country) If Under 1 Year 5. Social Security Number **Funeral** Vear! Days Hours Months 216-58-0881 Maryland 19, Director 'eb Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland n and Mental Hygiene.

is marked other than "natural", or items 23a or 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 7 is marked other than "natural", or items 23a or 28a-f show traumatic event, Ibs Modred Exeminar must be notified at 1X Yes 2 □ No Director Baltimore MD 10g. Citizen of What Country? 10f. Zip Code 10e Street and Number USA 21229 22 S. Athol Ave. Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 Specify: black 1 ☐Yes 2X No Specify. 2 3 ☐ Widowed 4 ₺ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b, Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) clerk 12 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last) Be Leroy McCardell 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) permit. Pages 1 and 2 s Department of Health ar Important: If item 27 is any injury or other trau 50 Pacton Pl; Baltimore, Maryland 21244 Pages 1 and 2 Nathalia Gordon - daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4□Donation 5 NOther (Specify) in state 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral S. rvice censee de, Director 655 W. Baltimore St; Baltimore, MD 21201 23a. Part 1. Enfor the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** DAUG disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner YEM if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and for use as the burial-trar Due to (or as a consequence of): MCCARDELL POLICHARY Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d, Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown icate has been signed by , page 2 should be detach 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ⋛ 3 Probably 4 ☐ Unknown 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed certificate 2.0 No 1 ☐ Yes 2 ☐ No 1 ☐ Yes 25. Was case referred to medical examiner? director, 26. Place of Death (Check only one) Be Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1, Inpatient 2 ER/Outpatient 3 DOA Certification: To this Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred After t Hospital or Attending 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No hours after death. 2 Accident 24 hours after deatle Funeral Director: completely filled in by the 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. the within To the 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ONATHAN 31. Date filed (Month, Day, Year) State 5 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month 3 06 15 AM 30 MITCHELL 2011 4c. County of Death 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death Baltimore Future Care Canton If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 9. Birthplace (State or Foreign Country) Maryland 8. Date of Birth (Month, Day, Year) Dec 21, 19 6. Sex 7. Age (In yrs. last birthday) 5. Social Security Number 1 □ M 2 1 F 212-28-4716 Yrs. Dec Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location tv Yes 2 □ No MD Baltimore 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21224 USA 508 Quail Street 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11 Marital Status Black, White, etc. I □ Yes 2 No f Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify white 3 ☐ Widowed 4 ₺ Divorced 16b, Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) restaraunt waitress unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Sumame) Irene Richardson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 21224 110 N. Belnord Baltimore, MD Kim Clubbs/friend 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State `4□Donation 5肽Other*(Specify)* in state 3tatendAnasong Board 655 W. Baltimore Street 21. Signatur of Roll III die Licensea de Wade Director 21201 Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 1 ☐ Yes 2 ☑ No 1 Yes 2 No 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA

Physician /Medical Examiner The law requires that the death certificate be executed

Physician

/Medical

Examiner

Funeral

Director

28a-f show

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or Items 23a

filed within 72 hours after Hygiene. hther than "natural", or Ite

permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other than any injury or other traumatic event, 1 a 1 000.

Baltimore, Maryland 21215-0036

Director

Funerai

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Completed

traumatic event, the Medical Examiner must be notified at

death with the Maryland

as the burial-transit the attending physician the for use as the buria detached ģ signed pe page 2 has certificate rector,

Division of Vital Records, P.O. Box 68760,

or Attending Physician:

To the Hospital 24 hours a

24 within 2

s after death.

Examiner Physician/Medical þ Completed Be P Certification:

9 Unknown

25. Was case referred to medical examiner? 1 ☐ Yes 2 No 27. Manner of Death 1 Natural 5 Pending

2 Accident

3 Suicide

29a. Certifier

Medical

State Registrar 4 Homicide

28a. Date of Injury (Month, Day investigation

28b. Time of

28c. Injury at Work? 1 🗌 Yes 2 🗌 No

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28d. Describe how injury occurred

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature a

29c. License number

29d. Date signed (Month, Day, Year)

completed cause of death (Item 23a)

31. Date filed (Month, Day, Year)

APR 05

6 Could not be

determined

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure	All Copies Are Legible.
State of Maryland / Department of Health and	d Mental Hygiene
Certificate of Death	Reg. N6
(First Middle Last)	2. Date of Death

		-	_ State	tate of Maryla			of Health of Deat			JIENE Reg. NO 1	0.1	1	100	05
			Registrar 1. Decedent's Name (First, Middle, Last)				0, 200.		2. Date of Dea	th	J-1-	1	3. Time of	
П	Physicia			Α.	Mitch	nell			Month	Day	20	ear	02	30 _A M
dity.	/Medic Examin		4a. Facility Name (If not institution, give stre	et and number)		4b. City, T	own, or Location	on of Death		4c. Co	ounty of	Death		
1			FRANKLIN Square				Rosec			(321		nore	
	Funeral		5. Social Security Number 6. Sex	7. Age (In y	rs. last birthday) 88 Yrs.	If Under 1 Months	Days Hour	der 24 Hrs. rs Min.	8. Date of Birtl (Month, Day Eptember	n /, <i>Year)</i> - 10 -19	322 1	. Birthpi Count Marv	lace (State of try) Land	or Foreign
	Director		217–18–1787 1 M M Usual Residence of Decedent		00				quitt	10/12	722			
	yland now		10a. State 10b. County	10c.	City, Town or Lo	cation						10	0d. Inside Ci	
:	a-fst	ctor	Maryland Baltimore		Dunda	alk							1 □Yes	2 M NO
:	or 28	Director	10e. Street and Number 6941 German Hill Ro	ad		10f. Zip (10g. Citize US		at Coun	try?	
	s 23a	eral			110 10		21222	Origin? (Spec	cify Yes or No-			Americ	an Indian,	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. If Health and Mental Hygiene, and T is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	by Funeral	11. Warta Status	Was Decedent Ever in Armed Forces? 1 □Yes 2 ▼No If Yes, Give Year or Dates:		was Decede If Yes, speci 1 ☐ Yes 2	ent of Hispanic fy Cuban, Mexi		Rican, etc.)	1		White, e	etc.	
	n 72 hou "natura edical E	Completed	15. Decedent's Educati (Specify only highest grade co	ompleted)	(Give	dent's Usual kind of work DO NOT use	Occupation k done during re retired)	most of workin	9	16b. Kind	of Busin	ness/Ind	lustry	
212	filed within Hygiene. xther than " ent, the Me	omo	6 years	College (1-4or 5+)	We	elder					n Rai			
73	should be filed and Mental Hyg s marked othe umatic event,	ō	17. Father's Name (First, Middle, Last) William H. Mitchell					other's Name rene Ph	(First, Middle, nelps	Maiden S	urname)			
ary	shou and M is mar	-	19a. Informant's Name/Relationship (Type.	Print)			(Street and Nu							
Z	1 and 2 Health tem 27 is		William R. Mitchell				n Hill	7					21222 own, State	
Baltimore,	permit. Pages 1 and Department of Heal Important: If item 2 any Injury or other once.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Rem 4 ☐ Donation 5 ☐ Other (Specify)		b. Place of Dispo cemetery, cre- endens of			April 201				•	arylan	d
Balti	permit. Departr Importa any Inju		21. Signature of Figure 1 Service License	unsley		7110 S	Ty Fund Sollers	Point	Road,	Dunda	alk, alk,	P.A. Md.	21222	
			23a. Part 1. Enter the disease, or complicate shock, or heart failure. Ust only one	ions that caused the cause on each line	leath. Do not en	ter the mode	e of dying, such	h as cardiac o	r respiratory a	rrest,			Approximation Interval Better Onset and	tween
LL.	Physician	6 TF	Immediate Cause (Final disease or condition	Abdomi	nal a	bsce	.55						س و و	
100 mg	/Medical Examiner		resulting in death)	Due to (or as a con										
	LXaiiiiici	<u>_</u>	Sequentially list conditions,	Due to (or as a con	sequence of):							+		
Je.	uted f insit	Examiner	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury	240 10 (0. 40 4 00.										
10	ficate be executed physician and s the burial-transit	Exa	that initiated events c. resulting in death) Last	Due to (or as a con	sequence of):									
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89)	ertifica ing ph e as th	Med	IF FEMALE:			7								
Вох	law requires that the death certificate be executed as been signed by the attending physician and 2 should be detached for use as the burial-transit	Physician/M	23b. Was decedent pregnant in the past 12 months?	. If yes, outcome of pro 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time	Fetal death 3	☐ Ectopic p				23	3d. Date Mon		Day	Year
Ö	the de	ysic	1 □Yes 2 □ No 9 □ Unknown	9 Unknown	or death 3	_ other (sp	CONY)							
σ.	uires that the de signed by the a d be detached f	by Ph	Part II. Other significant conditions contri	buting to death but not	resulting in the	underlying ca	ause given in P	Part I.			_		the cause of	
rds	quires								1 🗆	Yes 2	HNO 3	3∏ Prol	bably 4 🗆	Unknown
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on	ding h. After funer	tion	1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day, Yea		М	Work? 1 ∐Yes							
Division	Attending r death. ector: After by the fune	ifica	3 Suicide 6 Could not be	28e. Place of Injury - building, etc. (S	At home, farm, s	treet, factory	, office	:	28f. Location (Street and wn, State)	i Numbe	r or Rur	al Route Nu	mber,
Ö	tal or	Certification:	4 Homicide											
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Medical (29a. Certifier (Check only one) 1 Certifying Physic 2 Medical Examine	cian: To the best of my r: On the basis of exa and manner stated.	knowledge, dea mination and/or	ath occurred investigation	at the time, da , in my opinion	ate and place, n, death occuri	and due to the red at the time	e cause(s) , date and	and mar place, a	nner as nd due f	stated. to the cause	(s)
	To th withir To th comp	Me	29b. Signature and title of certifier	>		290	c. License num	ber			,	,	, Day, Year)	
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	1		30. Name an accordance of person who com	pleted cause of death	(Item 23a) (Type	e, Print)	DC 12	2.111		0 21	23-	1		
	\		Majid Cina, M,	32. Registrar's	Signature	Marie	171, 1	on think	-, 100			-		
	Sta	ate	APR 0 5 2011	and d.	back	9								

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) ^{Day} 2011 APRIL Physician/ 2 5:20 P M **MEIDBRAER** Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE 6101 PARK HEIGHTS AVENUE, If Under 1 Year If Under 24 Hrs. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) Funeral UKRAINE Min. 1 🛛 M 2 🗆 F Months Days Hours 218-33-6640 75 Yrs. Director Usual Residence of Decedent or 28a-f show 10d. Inside City Limits should be filed within 72 hours after death with the Maryland I and Mental Hygiene. 10a. State 10h County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Completed by Funeral Director 1 X Yes 2 □ No BALTIMORE MD N/A 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21215 USA 6101 PARK HEIGHTS AVENUE, 4E 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian Black, White, etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 X Widowed 4 Divorced WHITE Year or Dates 16a. Decedent's Usual Occupation 16b, Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 5+ Flementary/Seconday (0-12) CONSTRUCTION ENGINEER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည **MEIDBRAER** ANNA MOISEY t. Page 1 and 2 should be rtment of Health and Mer rtant; If item 27 is marki njury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12809 GORES MILL RD, REISTERSTOWN, MD 21136 MARGARITA DETUAR/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Page 1
Department of I
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) BALTIMORE 04/04/2011 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 21. Signature of Funeral Service Licensee May 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed burial-trar Due to (or as a consequence of): resulting in death) Last Physician/Medical Box 68760 IF FEMALE: use 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Year for 5 Other (specify) Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 DNo 3 Probably 4 Dunknown 1 Tes Completed 24. Were autopsy findings available prior to completion of cause of death? 24a. Was an autonsv 2 N 1 Yes 2 No Yes 25. Was case referred to medica 26. Place of Death (Check only one) Be Other: 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home မ 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner eath 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Matural 5 Pending 1 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, filled in by ☐ Homicide determined after City or Town, State within 24 hours a

To the Funeral C

completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the within 2 only one) 29d. Date signed (Month. Day. Year) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 For State Registrar Certificate of Death 1. Oecedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ 31 11:50P. Josephine M Nehila Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Gilchrist Balto. Towson Social Security Number If Under 24 Hrs. 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) If Under 1 Year **Funeral** (Month, Day Year) ec. 19.1937 1 □ M 2 🛣 F Months New Jersey Davs Hours Min. Yrs 142-28-6686 **Director** 73 Usual Residence of Decedent 10a. State 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location notified at Director 28a-f 1 Yes 2 No Md. Balto. Perry Hall 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 must be n Funeral 6 A Brookfarm Court USA items 2 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. "natural", or iter idical Examiner Black, White, etc 1 Never Married 2 Married þ Yes 2 XNo Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed alth and Mental Hygiene.
27 is marked other than "natun r traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Typesetter Newspaper Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Salvatore Amore Jennie Cannizzo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health 8 William T. Nehila, Sr. Spouse 6 A Brookfarm Court Perry Hall Department of Health Important: If item 27 any injury or other the once. 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State Bel Air Memorial 4-4-2011 BelAir, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home 21. Signature of Funeral Service Licensee 9705 Belair Road Nottingham, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between
Onset and Death Immediate Cause (Final Physician/ Y ears Medical resulting in death) Due to (or as a consequence Examiner Sequentially list conditions, Be Completed by Physician/Medical Examiner Due to for as a consequence of if any leading to immedicause. Enter Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed burial-tran that initiated events resulting in death) Last attending physician and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 the as for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months? Day 4 ☐ Pregnant at time of death g ☐ Unknown 5 Other (specify) signed by the a g 🗌 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 1 🗌 Yes should peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an certificate has birector, page 2 s autopsy Yes 2 No 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 1 Yes 2 No ျာ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) HOSONEY this 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28d. Describe how injury occurred After 1 Natural injury 5 Pending of Funeral Director: A Funeral Director: A sleted filled in by the fi Accident
Suicide Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🖳 crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor

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completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 [only one) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) le Sufe 4105 ute rantes

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #19a Per FH G919/2011 JH
State of Maryland / Department of Health and Mental Hygieney Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Dav Physician/ NGUYEN M of 6:05 , 7 UYET 1106 03 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's 6923 100th Avenue Lanham 9. Birthplace (State or Foreign Country)
Vietnam If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days (Month, Day, Year) Months Hours 1 □ M 2 🏻 F Director 214-96-2250 Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a State 72 hours after death with the Maryland Director 1 Yes 2 X No Lanham MD Prince George's 10g, Citizen of What Country? 10e, Street and Number 10f, Zip Code Funeral United States 20706 6923 100th Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced Asian Completed the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Technologist Health Care Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Tuc Tuduc Xuan Thi Le V. Nguyen 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6923 100th Avenue Lanham, Maryland 20706 Page 1 and 2 An Nguyen / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition Date 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Arundel Crematory 04-03-2011 Odenton, Maryland 21. Signature of Funeral Service Itemse 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final HEPATIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine HYPERBIL TRUB attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Fctopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Day 5 Other (specify) Pregnant at time of death ed by the a P.O. | been signed by t should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by DIABETES MELLITUS 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No HYPERTENSION 24a. Was an has autopsy performed? page certificate Yes 2 V 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မှ after death. Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Hospital or Attending 1 Natural 5 Pending 1 Tes 2 No ☐ Accident☐ Suicide Investigation 6 Could not be the 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier T. MALJIC M.D 01 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MARYLAND 20706 8116 ANHAM. ROAD SUITE GOUDLUCK 300

State Registrar (Month, Day, Year R 0 5 201 32. Registrary Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year EFRED CINE 1:06 PM 200 Medical 4a. Facility Name (if not institution, give street and numb **Examiner** 4b, City, Town, or Location of Death 4c. County of Death FRANKLIN SQUARE Rosedale HOSPITa Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 **XX**M 2 □ F Months Hours Min 0270371939 Maryland 215-36-0553 Director Yrs Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location traumatic event, the Medical Examiner must be notified at Director 10d. Inside City Limits Maryland Baltimore Essex 1 Yes 2 No 10e. Street and Number 5 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 305 Sassafras Road 21221 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. ō þ 1 Never Married 2XXMarried 2 No Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify. "natural", 3 Widowed 4 Divorced Specify Completed unk White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Carpenter Construction Be and 2 should be filed a Health and Mental Hydron 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Jerome Frederick North Edith May Birchett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mabel Joan North (Wife) 305 Sassafras Road, Baltimore, Maryland 21221 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2XX remation 3 Removal from State Bayview Crematory, Inc. 4/8/2011 4 Donation 5 Other (Specify) Baltimore, Maryland Signature of Funeral Service Li 22. Name and Address of Familianski Funeral Home, P.A. 1407 Old Eastern Avenue, Essex, Maryland 21221 art 1 Juner the disease, or complications that caused the death. Do not evier the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Pregnant at time of death Month Day Year 9 Unknown Unknown rate has been signed by r page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 Yes 2 No 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? ျ 1 🗌 Yes 2 No Other: 1 Inpatient 2 FR/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 Tes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April ^{Day} 2011 10:35A M William C. Nash Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City. Town, or Location of Death 4c. County of Death Baltimore Timonium Lorien Mays Chapel 5. Social Security Number Sex 1 X M 2 □ F 7. Age (In vrs. last birthday If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Dec. 18, Year) 937 Mary land Director 218-32-7699 73 Usual Residence of Decedent should be filed within 72 nouse and and Mental Hygiene.

7 is marked other than "natural", or items 23a or 28a-f show arice event, the Medical Examiner must be notified at 10a, State 10b. County 10c, City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Baltimore Timonium 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21093 USA 101 Oakway Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Was Decedon Armed Forces?
1 ☐ Yes 2 🔀 No Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 X No Specify. If Yes, Give Year or Dates Completed 3 - Widowed 4 - Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Electrician Baltimore County N/A Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Sophie Baublitz Howard Leon Nash 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh. Department of Health ar Important: If item 27 is Timonium, MD 21093 101 Oakway Road Shirley E. Nash/ Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Dulaney Valley
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State permit. Page 1 and Department of H any injury or 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 2011 Timonium, MD Signature of Funeral Service Licensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 Michael Flag1e 23a. Par T. Enter the disease, or complications that caused the death, Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death a Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner (D Sequentially list conditions, if any, leading to immediate cause. Enter Underlying sician and burial-transit Exami Cause (Disease or iinjury that initiated events resulting in death) Last death certificate be executed Due to (or as a consequence of) attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Year ed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🖟 Unknown Completed has been si e 2 should l Were autopsy findings available prior to completion of cause of 24a. Was an autopsy page performed? Yes 2 X N death? 1 Yes 2 No Hospital or Attending Physician: 124 hours after death.
Funeral Director; After this certifica eted filled in by the funeral director; t 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No Other: 1 Tes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide injury 5 Pending work? 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number 4 Homicide determined within 24 hours a

To the Funeral D

completed filled i Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 X Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated To the l within 2 To the only one 29b. Signature and title of certifier 201 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) N CHARLES 51

DHMH 17 Rev 7/2009

State Registrar

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31. Date filed (Month, Day, Year)

Box 68760

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Records,

Division of Vital

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32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marth **₹**¶У 3:33 201°1 Ам Salah Nasrallah Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X** M 2 □ F Months Days Hours Min. NOV. Dry2 Year 939 Lebarron 71 214-56-7796 Director Usual Residence of Decedent 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits should be filed within 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Lutherville Maryland Baltimore 10e. Street and Number 10f, Zip Code 23a or 10g. Citizen of What Country? by Funeral U.S.A. 21093 Court Long Ouarter "natural", or items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 🛣 No 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Specify: White 3 Divorced Completed Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12 College (1-4 or 5+) Medical Physician Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Nasrallah Adma Khoury Mitri 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21093 1508 Long Quarter Ct. Lutherville, MD. Nancy Nasrallah / Wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other page 200). 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 4/4/2011 Dulaney Valley Mem.Gdns. Timonium, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Functal Barrios Lissans 1050 York Road Towson, Maryland notications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the disease, or con Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final NOITHE Ph_sician/ disease or condition resulting in death) YEAV Medical Due to (or as a consequence of): Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 attending properties for use as as IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) n signed by the a Yes 2 No 1 Yes 2 5 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown Completed I 1 \square Yes After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence (A) Other (Specify) WOSHLU Hospital: 2 No ျ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred work?
1 ☐ Yes 2 ☐ No 1 Natural 5 Pending n 24 hours after death. e Funeral Director: A eleted filled in by the fu 2/ Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical -crtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check within 2 To the I only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 29b. Signature 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

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32. Registrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Year OFFICER -30PM UNICE 201 Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Howard Lorien Nursing Home Of Columbia Columbia Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 □ M 2 F Months Hours 236-44-4669 81 Country) West **Director** 02-08-1930 Virginia Usual Residence of Decedent 23a or 28a-f show mit. Page 1 and 2 should be filed within 72 hours after death with the Maryland bartment of Health and Mental Hygiene. Sortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at 10a. State Director 10c. City, Town or Location 10d. Inside City Limits Maryland Howard Highland 1 Yes 2 XNo 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 20777 13502 Allnut Lane USA 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Armed Forces? Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify. 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self-Employed vears Sewing Instructor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Mildred Siler William George Schneider permit. Page 1 and 2 should be Department of Health and Mer Important: If item 27 is marke any injury or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James Officer - HÚSBAND 13502 Allnutt Lane, Highland, MD 20777 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 04-04-2011 Baltimore, Maryland Crematory INC 22. Name and Address of Facility Cremation Society Of Maryland INC re of Funeral Service Licensee Patrik FLeming Road, Baltimore, Maryland 21228 299 Frederick Ba. Part 1. Enter the disease, or complication tions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, are on each line. shock, or heart failure. List only or Interval Between Onset and Death Immediate Cause (Final h sician/ disease or condition resulting in death) MARKEN Medical Due to (or as a consequence of) √ Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit law requires that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death Month been signed by the sales Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has t autopsy Hospital or Attending Physician: The performed' After this certificate 1 Yes 2, No 1 Yes 2 No the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 🗌 Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: Natural 28d. Describe how injury occurred 5 Pending work 1 \square Yes 2 🗌 No after death Director; / Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) completed filled in by 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Frantionen T. The cost of my knowledge death occurred at the time, date and place, and due to the cause(c) and manner as stated. (Check only one the within To the 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) M02045 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene
Amend Item 26 per verb., g914.04/07/2011dhb
Certificate of Death
Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ Day 054 Opher EMMa 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Randallstown Hospital ER-Baltimorn North west If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min. 1 - M X - F Months Days Hours 1921 1921 Couvinginia Director 89 228-28-8242 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c, City, Town or Location **Funeral Director Baltimore** 1 Yes 2 No **Baltimore City** Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 226 North Monastery Avenue 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Was Decedent Ever in U.S. Race - American Indian. Black, White, etc. Armed Forces? ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 ¥ Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working (Specify only highest grade completed) Own Home permit. Page 1 and 2 should be filed within 73 Department of Health and Mential Hygleine. Important: If item 27 is marked other than any injury or other traumatic event, the Me life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname Rosetta Cook 17. Father's Name (First, Middle, Last) ၉ Peter Hill Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2229 Lawnwood Circle Baltimore, Maryland 21207 19a. Informant's Name/Relationship (Type, Print) Carolyn Blakeney 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🔀 Burial 2 🗌 Cremation 3 🗌 Removal from State Owings Mills, Md. 04/05/11 Garrison Forest Veterans Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 21. Signature of Fune Service Lice 23a. Parkl. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to (or as a consequence of): Ph_sician/ disease or condition resulting in death) Medical Examiner (monory Sequentially list conditions, if any lead of the cause. Enter Underlying Cause (Disease or iinjury Examiner a consequenc To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the tuneral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Year Month Day Pregnant at time of death 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? extremity PVD, positive lower 1 ☐ Yes 2 ☐ No 3 🔀 Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an COPD, hypertusia autopsy performed? Yes 2 2 No 1 Yes 2 No Vita 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other 2 📈 No Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA + Sharsing Home 5 Residence 6 Other (Specify, o 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work? injury 1 🔼 Natural 5 Pending Division Investigation M Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of ce 29d. Date signed (Month, Day, Year) d \$\$68783 3/30/11

Registrar DHMH 17 Rev 7/2009

State

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print),

Michael L. dewit mb., Northwest

32. Registrar's Sig

Michael Li dewit

APR 0 5 2011

31. Date filed (Month, Day, Year,

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 2011 Month Physician/ 4:17 A M Olszewski April John Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Towson Gilchrist Hospice Center 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** Hours Months Days 1**X** M 2 □ F May 19, Year 950 Maryland 212-56-9228 60 **Director** Usual Residence of Decedent show 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ms 23a or 28a-f shorements and second Director 1 Yes 2 XNo Nottingham Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 48 Lerner Court 21236 items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11, Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 XYes 2 No
If Yes, Give the Medical Examiner Black, White, etc 6 1 Never Married 2 Married ρ Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 XNo Specify: Specify: "natural", 3 Widowed 4 Divorced Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Emergency Alarm Co. Dispatcher 12 years years event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot r other traumatic ever မ Delores D. Seibert John B. Olszewski II 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 48 Lerner Court, Nottingham, Maryland wife Renee Olszewski 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Aprilate 11, 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Owings Mills, Maryland Carrison Forest VA. Cem. 2011 of Funeral Seffvice Live 21. Sig z ture Connelly Funeral Home Of Dundalk, P.A. 7110 Sollers Point Road, Dundalk, Md. 21222 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death sho Imme ate Cause (Final Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Exam Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? for Month Year Day 4 Pregnant 9 Unknown Pregnant at time of death 2 No ed by the a detached 1 9 Unknown as been signed by the 2 should be detach∈ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a, Was an prior to completion of cause of death? Jas funeral director, page 2 performed' certificate 1 Yes 2 No Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 ☐ Yes 2 ☐ No Other: 4 Nursing Home 5 Residence 6 Other (Specify) ER/Outpatient 3 DOA မ 1 Inpatient 2 I 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: After 1 Natural 5 Pending after death. Director: Aft within 24 hours after death.

To the Funeral Director: All completed filled in by the fu 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🚅 🇲 certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 2

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State Registrar 31. Date filed (Month, Day, Year)

32. Registrar's Signature

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

KUMA

71040

2 Te 4105

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day Physician/ A^{M} John M. Page Jr. Apri] 2011 11:55 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Hospice Of the Chesapeake Tate House Linthicum Heights Anne Arundel If Under 1 Year If Under 24 Hrs. Social Security Number 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** Min 12 31 Year) 947 Country) 1 X M 2 □ F Director 215-50-2462 63 Maryland Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10a, State 10b. County 10c. City, Town or Location 10d, Inside City Limits be filed within 72 hours after death with the Maryland Director Bowie Maryland Prince Georges 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20715 USA 15480 Annapolis Road, Suite 202-149 ral", or items ? 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 X No Specify: Specify: WHITE 3 🗆 Widowed 4 😾 Divorced Year or Dates It of Health and Mental Hygiene.

If item 27 is marked other than "natur or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Government Fire Fighter 12 years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည John M. Page, Sr. Lillian Knott 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20715 15480 Annapolis Road, Suite 202-149 Bowie MD Michelle Beasley-DAUGHTER 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State permit. Page 1 a
Department of IImportant: If ite
any injury or ot 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Metro Crematory INC 04-05-2011 Baltimore, Maryland 22. Name and Address of Facility Cremation Society Of Maryland, Patrik FLeming İNC 299 Frederick ROad, Baltimore, MD 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final METASTATIC MELAN OMA Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No Month Dav To the Hospital or Attending Physician: The law requires that the dea within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached it 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence Of Other (Specify) Hospics 1 Yes Certificate: To 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manger of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred work?
1 Yes 2 No **Natural** injury 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 00064852 04/04/2011 HEMATOCOGIST CONCOURSE 10 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person RAVIN GARG ANNAPOUS MEDICAL PARLUMAY. 2001 31. Date filed (Month Year) 32. Registrar's Signature State Registrar

Baltimore, Maryland 21215-0036

Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 03-31-2011 ay 400 P William Carl Prinke Jr Medical 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Forest Hill Harford Bob Hooper Hospice Social Security Number 7. Age (In vrs. last hirthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 X M 2 □ F Months Days Hours Min 10-18-1948 213-52-7481 62 MD Director Usual Residence of Decedent 10b. County 10d. Inside City Limits 10a, State 10c. City, Town or Location Director r 28a-f sl notified 1 ☐ Yes 2 🗓 No MD Harford Bel Air 10e. Street and Number 10f. Zip Code ō 10g. Citizen of What Country? "natural", or items 23a or idical Examiner must be Funeral 202 Mary Jane Lane 21015 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces?

1 X Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1 Never Married 2 Married by Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced Completed the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Financial Manager Defense Industry Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 William Otto Carl Prinke Sr Dorothy Vanni traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other traconce. 202 Mary Jane Lane BelAir, MD 21015 Mary Prinke (Wife) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 K Cremation 3 Removal from State 04-04-2011 Baltimore, MD Bayview Crematory 4 Donation 5 Other (Specify) 22. Name and Address of Facility Schimunek Funeral Home of BelAir 21. Signature of Funeral Service Licenses Inc 610 W. MacPhail Rd BelAir, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ STAGE disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ Box in the past 12 months?
1 ☐ Yes 2 ☐ No for Year Month Day Pregnant at time of death be detached 9 Unknown P.O. ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has page 2 performed Yes 2 certificate 2 No 1 Yes or Attending Physician: 25. Was case referred to medical Division of Vital director, 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence ျပ 1 🗌 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA this 28a. Date of injury (Month, Day, Year) 27. Manner of Death filled in by the funeral Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After Natural 5 Pending work? 1 ☐ Yes 2 ☐ No Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completed 29b. Signature and til 29c. License number 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print) 30. Name and ddre P State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ Roy W. Painter 2011 6:00 A Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
Baltimore 4b. City, Town, or Location of Death Examiner Essex 808 Creek Road If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral 212-42-2520 July 22, Year) 943 1 🗆 M 2 🗆 Months 67 Yrs MD **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore Essex 1 🗆 Yes 2 🔀 No 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Examiner must be Funeral 23a 808 Creek Road 21221 USA items ? 72 hours after death Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 Mo Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. 1 Never Married 2 Married 0. þ Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes Give Specify: White 'natural", Completed 3 Widowed 4 Divorced Year or Dates he Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) than " Constellation Elementary/Seconday (0-12) College (1-4 or 5+) 8th Mechanic and Mental Hygie is marked other Be permit. Page 1 and 2 should be filed of Department of Health and Mental Hyg Important: If item 27 is marked other any injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Roy Clinton Painter Mary Edna Harris 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carol Lambo /wife 808 Creek Road Baltimore MD 21221 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place)
Bayview Crematory 20a. Method of Disposition 20c. Location - City or Town, State ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 4/4/11 Baltimore MD 4 Donation 5 Other (Specify) 21. Signatura of Funeral Service Licensee 22. Name and Address of Facility 300 Mace Ave. Balto. MD 21221 Connelly Funeral Home of Essex 23a. Part 1. Enter the disease, or complications that caused the beath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ 006 disease or condition resulting in death) DroNaru Medical Due to (or as a cons of ence of Examiner CVII Sequentially list conditions. Examine it any, leading to infriedate cause. Enter Underlying Cause (Disease or iinjury (of as a consequence of: attending physician and for use as the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 d. IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 🗆 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant a g ☐ Unknown the detached 9 I Unknown Division of Vital Records, P.O. by ate has been signed lagge 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 ☐ No 3 Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Hospital or Attending Physician; The law certificate has autopsy performed? Yes 2 No 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 X No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 \square Pending injury 1 Natural 1 Yes 2 No within 24 hours at er deeth.

To the Funeral Director A completed filled in by the fu Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 10 30. Name and address of person who completed cause of death (Item 23a) 9106 Van 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ AM 1042 GAANVILLE /ILLIAM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Howard Columbia Howard County General Hospital 8. Date of Birth (Month, Day, Year) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Funeral 1 ₹ M 2 □ F Months Washington, DC Feb. 1944 Director 219-42-3114 6. Usual Residence of Decedent 28a-f shov 10b. County 10d, Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shov 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 🗆 Yes 2 😾 No Laurel MD Howard 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral Robinson Blvd 20723 9834 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc. Completed by 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: If Yes, Give Year or Dates White 3 Widowed 4 Divorced of Health and Mental Hygiene.
item 27 is marked other than "natur
other traumatic event, the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) US Postal Service 12th Mail Handler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Burns Pinkard Audrey 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary L. Pinkard/Wife Robinson Blvd. 9834 Laurel MD 20723 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Date o I cemetery, crematory or other place) ☐ Burial 2XXCremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or 3/31/2011 Odenton, MD 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crem. 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Donaldson Funeral Home, P.A. M01103 313 Talbott Avenue, Laurel, MD 23a. Part / Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final Approximate Interval Between Onset and Death Pnysician/ MYUCARSI disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed as the burial-tran and that initiated events Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Division of Vital Records, P.O. Box 68760 attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death use 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months? for Month Day Year Pregnant at time of death 2 No g Unknown should be detached 9 Unknown the signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy page 2 performed? I ☐ Yes 2 No certificate funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital Other: 2 No 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work?
1 ☐ Yes 2 ☐ No 27. Manner of Death 28d. Describe how injury occurred Certificate: s after death.

I Director: After to in by the funeral injury 1 Natural 5 Pending Accident Investigation 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a To the Hospital Medical 1 🖊 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) LO 11 0058051 29

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Registrar

DHMH 17 Rev 7/2009

State

Columbia, MD 21042

Cedar Lane,

\$2. Registrar's Sign ture

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Walter Atha,

31. Date filed (Month, Day, Year)

5755

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ Paul Perdew April 2011 10:40 Medical 4a. Facility Name (if not institution, give street and number, 4b. City. Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Center for Hospice Towson 7. Age (In yrs. last birthday If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **XX**M 2 🗆 F Days Hours Min 0770171959 Maryland 213-80-7706 51 Director Usual Residence of Decedent 28a-f show 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland must be notified at Director Maryland Baltimore Middle River 1 Yes 2XXVo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? ö Funeral 23a 9618 Conmar Road 21220 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian. 11. Marital Status Examiner Armed Forces? Black, White, etc. ö 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XXNo Specify: Specify: White 3 Widowed 4 Divorced "natural", Completed event, the Medical 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Driver Trucking Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) of Health and Mental H fitem 27 is marked ot r other traumatic ever မ James Nelson Perdew Verna Ann St.Clair 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau Kristen Foster (Daughter) 135 South Meadow Drive, Glen Burnie, Maryland 21060 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place, 1 Burial 2XXCremation 3 Removal from State 4 Donation 5 Other (Specify) Bayview Crematory, Inc. 04/04/2011 Baltimore, Maryland 22. Name and Address of Facility
Bruzdzinski Funeral Home, P.A.
Bruzdzinski Funeral Home, Maryland 21221 permit. majure of Purchas Sarring Linear 23a. Part 1 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death ediate Cause (Final Physician/ En disease or condition resulting in death) Medical Due to (or as a consequence of **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami burial-transit Cause (Disease or linjury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day Pregnant at time of death cate has been signed by the page 2 should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Inknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? After this certificate Yes 2 No 25. Was case referred to medical director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 1 ☐ Yes 2 ☑ No ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred iniury 1 Natural 5 Pending 24 hours after death. Funeral Director: At 2 Accident
3 Suicide
4 Homicide Investigation the f 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Funer completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 3 29b. Signature and title of certifi 29c. License number 29d. Date signed (Month, Day, Year)

Registrar

DHMH 17 Rev 7/2009

State

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MD

32. Registrar's Signature

Ni Chean

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 2 Pope Month 4 Physician/ Noah 2330 PM Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** contes Multi-Meetical Baltimore Towson Genesis If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 9. Birthplace (State or Foreign Country) **5** C Age (In yrs. last birthday) 73 Yrs. 8. Date of Birth **Funeral** - 2960 Worth, Day, Director Usual Residence of Decedent 28a-f show 10a. State 10d. Inside City Limits 10b. County Examiner must be notified at Director MD 1. Por es 2 ☐ No more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral 23a us A Side items 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces' Black, White, etc. 1 ☐ Yes 2 No If Yes, Give 1 Never Married 2 Married "natural", or þ Baltimore, Maryland 21215-0036 Black 1 Yes 2 No Specify Completed 3 Divorced 4 Divorced Year or Dates event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired 15. Decedent's Education (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Mea Elementany/Seconday (0-12) College (1-4 or 5+) Docta Be Father's Name (F rst. Middle. La Mother's Name (F) ပ္ a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number 4113 Sunnyside Ave., Bal City or Town, State, Zip Code) Ho 20b. Place of Disposition colmetery, cremate 20a. Method of Disposition 1 🞾 Burial 2 🗌 Cremation 3 🗀 Removal from State -2011 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final severe Physician/ Stenosis disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to for as a consequence of To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has t een signed by the attending physician and completed filled in by the funeral director, pc.ge 2 should be detached for use as the burial-transit J'XOGKH that initiated events Due to (or as a consequence of resulting in death) Last Physician/Medical Diaphral mat Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death g Unknown 9 Unknown Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Obstructive Chronic 1 Tes 2 X No 3 Probably 4 Unknown ficate has t een sig v, page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? - Disease 24a. Was an autopsy perform 1 🗌 Yes 2 🗌 No 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 🔼 No ျပ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: 5 \square Pending 1 🔀 Natural 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Zertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number B D71493 30. Name and address of person who completed cause of death (Item 23a) (Type, Print Towson, MD 21204 Rd. JOCK Farah B02019 7700 31. Date filed (Month, Day, Year) State 5 Registrar

Baltimore, Maryland 21215-0036

Division or Vital Records, P.O. Box 68760,

		For State Registrar	State of Ma	aryland			of Health of Dea		lental Hy	giene		10822
		Decedent's Name (First, Middle, Last	st)						2. Date of De	eath	Voor	3. Time of Death
Physicia /Medica	_	Mahlon Fay Perki	ns Jr.				_		March	28°	201	1 2:30 A M
Examine	era III	4a. Facility Name (If not institution, give	e street and number)				own, or Locati			4c. Cou	inty of Death	1
	4	Roland Park Plac		the see to a	t foliationin ()	Ba J	Ltimore	der 24 Hrs.	8. Date of Bir	rth	O Rieth	nplace (State or Foreign
Funeral Director		5. Social Security Number 127–24–4907 6. S	M 2□F	92	Yrs.		Days Hou	rs Min.	May 9,	ay, Year)	Cot	hina
and w		Usual Residence of Decedent 10a, State 10b. County		10c. City, T	own or Loc	ation						10d. Inside City Limits
Aaryla f sho ed at	ō	MD			ltimo							1 X Yes 2 □ No
with the Na or 28a-	Director	10e. Street and Number 830 W. 40th St	455			10f. Zip C	ode 211			10g. Citizen USA	of What Co	untry?
	by Funeral	11. Marital Status 1 □ Never Married 2 Married 3 □ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 X Yes 2 N If Yes, Give		_ If	/as Deceder Yes, specif	y Cuban, Mex	rican, Puerto	ecify Yes or No Rican, etc.)		Race - Amer Black, White ecify: W	
"natural"		15. Decedent's Ed (Specify only highest gra			(Give k	ent's Usual ind of work O NOT use	done during i	most of work	ing	16b. Kind o	f Business/I	ndustry
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uld be fill fental H rked oth	To Be	17. Father's Name (First, Middle, Last, Mahlon Fay Perki							e (First, Middle Gooden	e, Maiden Suri	name)	
nd 2 shou lith and N 27 is mai r traumai		19a. Informant's Name/Relationship (Lovell Perkins							al Route Numb Baltin			
Pages 1 au lent of Hea nt: If item ry or othe	Ì	20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Specif		20b. Plac	e of Dispos etery, crem	ition (Name atory or oth	of er place)	1	Date	20c. Location	on - City or	Town, State
permit. Departm Importa any inju	Ì	21. Signature of Funeral Service licer Ronald S		ctor					te Anat St; Bal	-		21201
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hysician /Medical	ĺ	Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as			CA	v d w	my	Mar (T)	4		
Examiner	e	Sequentially list conditions,	b	a consequen	nce of):							
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The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 □ Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal de	eath 3 🗌	Ectopic preç Other <i>(sp</i> ec				23d. Date of delivery Month Day Year		
w requires that to be signed by should be detact	۵	Part II. Other significant conditions of	contributing to death bu	ut not resultir	ng in the un	derlying cau	use given in P	art I.		tobacco use		the cause of death?
The law rec te has beel age 2 shou	Completed								24a. Was auto perf 1 Yes	s an 2 opsy formed?	4b. Were au prior to death?	atopsy findings available completion of cause of
sician: The la certificate ha irector, page 2	Be C	25. Was case referred to medical					26. P	lace of Deat	h (Check only			2,2110
nysic nis ce I direc	2 2	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 ☐ Inpatie	nt 2 ER	l/Outpatient	3□ DOA	Other: 4	Nursing Ho	ome 5 Res	sidence 6	Other (Spe	cify)
nding Ph th. r: After the e funeral		27. Manner of Death 1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Inju (Month, Day		Bb. Time of Injury	284 M	c. Injury at Work? 1 ☐ Yes	2 🗆 No	28d. Describe	how injury oc	ccurred	
To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director, to the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not b determined	28e. Place of injubuilding, etc	ury - At home c. (Specify)	e, farm, stre	et, factory,	office		28f. Location City or To	(Street and Nown, State)	umber or Ru	ural Route Number,
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To th withir To th comp	Me	29b. Signature and title of certifier				29c.	License numb				-	h, Day, Year)
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		30. Nameland address of person who	n m.n.	590	1 10	Print)	CHAV	1247	treet	BANT	imore	Mary long
Stat Registra	26	31. Date filed (Month, Day, Year)		ar's Signatur	bar	4			į	•		4

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DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ 201^{Yea} MARCH 11:40P M MILTON PUSHKIN Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death BALTIMORE GILCHRIST HOSPICE CARE TOWSON 9. Birthplace (State or Foreign Country) NY If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 🕅 M 2 🗆 F Days Months Hours Mir 05/24/1914 Director 220-07-2823 96 Yrs. Usual Residence of Decedent 28a-f show the Maryland 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director 1 Yes 2 X No MD BALTIMORE BALTIMORE ò 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? the Medical Examiner must be Funeral with 1 23a 2304 BAYTHORNE COURT 21209 items ? 72 hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

Yes 2 \[\text{No} \] Black, White, etc. 1 Never Married 2 M Married ō δ Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates "natural", Completed 3 Widowed 4 Divorced Specify: WHITE 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. within 7 Elementary/Seconday (0-12) College (1-4 or 5+) 12 MANAGER HOME IMPROVEMENT Be be filed \ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ည permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic injury or other traumatic ISAAC PUSHKIN ROSE SISKIND 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2304 BAYTHORNE COURT, BALTIMORE, MD 21209 MYRA PUSHKIN / WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 4 ☐ Donation 5 ☐ Other (Specify) OHEB SHALOM MEM. PARK:04/03/2011 REISTERSTOWN, MD 21. Signature Funeral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ months disease or condition Medical resulting in death) Due to (or as a contequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam Cause (Disease or linjury tran that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician for use as the buria Physician/Medical b Hospital or Attending Physician: The law requires that the death certificate be to 24 hours after death.
Funeral Director: After this certificate has been signed by the attending physicial P.O. Box 68760 yes, outcome of pregnancy
☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 1 Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 page 2 s 2 | No 1 TYes 25. Was case referred to medical funeral director, 26. Place of Death (Check only one) Be examiner? Other: 4 \(\triangle \text{ Nursing Home } 5 \) Residence 6 \(\text{Nother (Specify) W05 DLC)} 1 🗌 Yes 2 No ည 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 X Natural injury work? 1 Yes 2 No Investigation Accident filled in by the 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 1 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. соmpleted Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 6701

UHAZVES

Registrar's Signature

31. Date filed (Month, Day, Year)

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	Medic Examin		Elizabeth J. Ro 4a. Facility Name (If not institution		er)		4b City 1	own or	Location o	of Death	April	_,_	2011 4c. County	of Death			
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	Funeral		5. Social Security Number	6. Sex 7.	Age (In yrs. la	ast birthday)	If Under	1 Year	If Under		8. Date of Bi	rth		9. Birtl	thplace (State or Foreign		
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21215-0036	within 72 hours after death with the Maryland glene. et than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at the Medical Examiner must be notified at		Elementary/Seconday (0-12)	College (1-4	or 5+)		Arti						Self	-Emp.	loyed		
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Baltimore,	permit. Pag Department Important: any injury o		4 Donation 5 Other (S			ro Cre									Maryland Maryland	-	
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	e deal the at hed fo	ysic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4 L Pregna 9 Unknov	nt at time of c	death 5∟	Other (spe	ecify)					I	21101	Day Year		
O.	The law requires that the ate has been signed by t page 2 should be detach	УР	Part II. Other significant condition	ons contributing to dea	th but not res	ulting in the u	nderlying c	ause giv	en in Part I	l.	23e. Did	tobacc	o use cont	ribute to	the cause of death?	,	
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0	ing P	ate:	27. Manner of Death 1 ☑ Natural 5 ☐ Pendir	28a. Date of (Month,	injury <i>Day, Year)</i>	28b. Time of injury	- 1	lc. Injury work	?	- 1	28d. Describe	how inj	jury occurr	red			
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Division of	after Direction by	Cer	4 Homicide determ		etc. (Specify		et, factory,	Office			City or To			er or Hun	al Route Number,		
_	To the Hospital or Attending Physician: The law within 24 Hours after death. To the Funeral Director. After this certificate has completed filled in by the funeral director, page 2.	Medical	29a. Certifier 1 Certifying	Physician: To the besi	t of my knowl	edge, death o	occured at t	he time,	date and p	olace, an	d due to the ca	ause(s)	and mann	er as stat	red.	etatod	
	the H nin 24 the Fu	Med	only one) 3 Certifying	xaminer: On the basis Nurse Practioner: To			leath occurr	ed at the	time, date			ne caus	e(s) and m	anner as s	stated.	stated.	
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	10		30. Name and address of person	-	or death (Item			יוו	ch-	naa .	Rd Suit	1	QO ID		21037		
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JOSEPH REYNOLDS

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	death items ner m		11. Marital Status		12. Was De	cedent Eve	er in U.S.	13.	Vas Deced	ent of His	spanic Oriç	gin? (Spe	cify Yes or No- Rican, etc.)			ce - Americ		
36	after al", or xamii	d by	1 X Never Marri		ed 1 Ye If Yes, 0 Year or		0		I ☐ Yes			,			Specify	F-7	hite	
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Baltimore.	permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If tem 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disp 1 XBurial 2 4 Donation	Cremation	3 ☐ Removal fro	om State	cer	ace of Dispo metery, crer athedr	natory or o	ther place	e)	April 201	Date 108,			- City or To		
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			23a. Part 1. Enter shock, or her	he disease, or t ailure. List o	complications tha	t caused the	he death.	Do not ente									Approximate Interval Between	
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Division of Vital Records.	To the Hospital or Attending Physician; The law requires that the death certificate I within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phys completed filled in by the funeral director, page 2 should be detached for use as the		4 Homicide	determi	buil	lding, etc. ((Specify)						City or To	wn, Stat	e)		l Route Number,	
	the Hosp hin 24 ho the Fune npleted f	Medical	(Check 2 only one) 3	Medical E	Physician: To the caminer: On the b Nurse Practione	asis of exam	mination a	and/or inves	tigation, in a	ny opinio red at the	n, death od time, date	curred at	the time, date	and plac ne cause	ce, and due(s) and m	ue to the ca nanner as s	use(s) and manne tated.	er stated.
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	Sta	te	JACKIE 31, Date filed (Monti	h, Day, Year)		Registrar's		EY VA	LLEY	KU.	T.TW(NLUN	1, MD 2	109:				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Yea Physician/ 22:50 M William Jacob Rush, Jr 3) 03 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner SAMARITAN HOSPITA MD BALTIMORE N/AIf Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral 7. Age (In vrs. last birthday) Days Hours OCT . 17 1**√** M 2 □ F year 926 West Virginia 235-32-2297 Director 84 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f show ampionant: If item 27 is marked other than "natural", or items 23a or 28a-f show ampirity or other traumatic event, the Medical Examiner must be notified at once. 10a, State 10c. City, Town or Location 10d, Inside City Limits Director Baltimore Parkville MD 1 Yes 2 XNo 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 21234 8617 Rock Oak Road 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1

✓ Yes 2 No
If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify: white 3 X Widowed 4 ☐ Divorced Year or Dates 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Catering Food and Beverage 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Sarah Cavalier William Jacob Rush, Sr 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8617 Rock Oak Road-Parkville, Maryland 21234 William Rush, III-son 20b. Place of Disposition (Name of cemetery, crematory or other place)

Evans Funeral Chapel and Cremation Services Pelair 20a. Method of Disposition 20c. Location - City or Town, State 1 Durial 2 Kernation 3 Removal from State Forest Hill, Maryland 4 Donation 5 Other (Specify) 3.2011 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final ASPIRA Physician disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Securitielly list nonditions if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Cause (Disease or iinjury IRTAL FIRRIU that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by MYELODYSPLASTIC SYNDROME, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an PANCYTOPENIA, COLON ADENOCARLINOMA autopsy performed? Yes 2 N To the Hospital or Attending Physician: The within 24 hours after death.

To the Funeral Director; After this certificate I 1 ☐ Yes 2 ☐ No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner?
1 ☐ Yes 2 ☑ No 10 Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending Accident 1 ☐ Yes 2 ☐ No Investigation
6
Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a, Certifier 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated satist Kabra 03,31,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

APR 05

BALTIMORE, 21239

SATISH KABRA, MD, 5601, LOCHRAUENBUD.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day 2011 April 2 Lester Elwood Robinson P^{M} 2:51 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1413 Hopewell Avenue Baltimore Essex 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Days West Virginia 1 XM 2 □ F Months Hours Min (Month, Day, Year) 07/04/1933 **Director** 234-54-8638 Usual Residence of Decedent or 28a-f show e notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Baltimore Essex 1 Yes 2 X No 10e. Street and Number should be filed within 72 hours after death with the nand Mental Hygiene.
Is marked other than "natural", or items 23a or raumatic event, the Medical Examiner must be n 10f. Zip Code 10g. Citizen of What Country? Funeral 1413 Hopewell Avenue 21221 U.S.A. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give 3 Widowed 4 ☐ Divorced Specify: Korea White Completed Year or Dates. 15 Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Mechanic Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Paul Robinson Ruth Barr other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health Jeffrey Robinson (Son) 1607 Riverwood Circle, Joppa, Maryland 21085 20a, Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State Page 1 permit. Page 1 Department of Important: If it any injury or o cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State Bayview Crematory, Ind. 04/04/2011 | Baltimore, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ski Funeral Home, P.A. W. iohn 1407 Old Eastern Avenue, Essex, Maryland 21221 23a/ Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) conas AN Medical Due to (or as a cons-quence of): **Examiner** Sequentially list conditions. if any, leading to immediate cause. Enter crosslying Cause (Disease or iinjury Due to (or as a consequence of): Exami physician and s the burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical P.O. Box 68760 attending p IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death Yes 2 □ No ed by the a detached f g Unknown 9 Unknown signed k Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, or Attending Physician: The law equires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed een 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed certificate 1 ☐ Yes 2 ☐ No Yes 2 director, æ 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Presidence 6 Other (Specify) 2 No ျှ 1 Inpatient 2 ER/Outpatient 3 DOA this s after death.

I Director: After this of in by the funeral d 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation 3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital o within 24 hours af To the Funeral Di completed filled in Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d, Date signed (Month, Dav. Year) 30. Name and address of person who complete ed cause of death (Item 23a) (Type, Print) 10 Philadelph heldon Mi 31. Date filed (Month, Day, Year) State

Registrar

APR 0 5 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. I. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Parch 05 Demiyah Roberson Medical 4a. Facility Name (if not institution, give street and number, 4b_City, Town, or Location of Death 4c. County of Death **Examiner** Maryland General Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral 1 - M 2X-XF Months Hours Min. 0 Director NΑ Usual Residence of Decedent or 28a-f show notified at 10a. State 10b. County with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director XX Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? "natural", or items 23a o Funeral 2235 Penrose Avenue 21223 USA hours after death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11 Marital Status 14. Bace - American Indian Armed Forces?
1 ☐ Yes 2 🛣 No Black, White, etc. African þ XX Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2X No Specify: Specify: American 3 Widowed 4 Divorced Completed er than "natur ; the Monical I Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be flied within Department of Health and Mental Hygiene Important: If item 27 is marked other the any injury or other traumatic event, the sonce. Child Child Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dameron LaKesha Bridges Roberson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LaKesha Roberson-Mother 2235 Penrose Avenue Baltimore MD 21223 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 X Cremation 3 Removal from State Catonsville, MD 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory 03-26-11 21. Signature of Funeral Service Licens 22. Name and Address of Facility Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a sequence of) Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of): Hospital or Attending Physician, The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery ☐ Ectopic pregnancy ☐ Other (specify) ___ for in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death ate has been signed by the a page 2 should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 \square Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 Yes 25. Was case referred to medical completed filled in by the funeral director, Be 26. Place of Death (Check only one) examiner? 2 INO မ 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred work? 1 ☐ Yes 1 Natural injury 5 Pending Accident Investigation 24 hours after deat Funeral Director: 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) within 2 To the I the and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

39. Registar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Cecil L. Redman, Sr. 2011 9:00 P. M April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Stella Maris Hospice Timonium Baltimore Social Security Number 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 1 X M 2 □ F Months Hours October 13 79 Virginia Director 411-56-3552 Jsual Residence of Decedent and Mortal Hygiene.
is marked other than "natural", or items 23a or 28a-f show Maryland 10b. Count City, Town or Location
Nottingham 10d. Inside City Limits Director Baltimore 1 Tes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8 Leinster Garth Court 21236 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces Black, White, etc. 1 Never Married 2 X Married Completed by 1 Yes If Yes, Give Baltimore, Maryland 21215-0036 Specify. White 1 Yes 2 X No Specify: Kõrea 3 Widowed 4 Divorced Year or Dates. permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Plumber Self Employed Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) George Hall Elizabeth Redman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Yong Suk Redman/wife 8 Leinster Garth Court Nottingham Maryland 21236 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place 20c. Location - City or Town, State Date 1) Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Lakeview Memorial Gardens 4/5/11 Sykesville Maryland 21. Signatury of Funeral Service Licensi 12. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ PARKINSONS DISEASE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): Cause (Disease or iinjury that initiated events physician and s the burial-trans Due to (or as a consequence of) resulting in death) Last Physician/Medical 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ P.O. Box in the past 12 months?
1 Yes 2 No Day Year Pregnant at time of death 9 | Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? 1 Yes 2 No **Division of Vital** 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital Other ျ 1 Yes 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 X Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred Hospital or Attending 1 X Natural injury work? 5 Pending Acciden

Suicide Accident Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗶 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and tide 29c. License number erson who completed cause of death (Item 23a) (Type, Print) 2300 DULANEY VALLEY RD. JACKIE JONES, CRNP TIMONIUM,

DHMH 17 Rev 7/2009

State Registrar

APRIL 2, 2011

REDMAN

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible. amend #1000c Per ANA BD 6914 4/05/2011 JH State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) ^D28 March 20^Y1^a1 1:30 Ам Physician/ Jean Ristine Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Emeritus Assisted Living 9. Birthplace (State or Foreign Country) Virginia If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan 9, 5. Social Security Number **Funeral** Months Days Hours 226-24-3807 1 □ M 2**X** Director Usual Residence of Decedent ed other than "natural", or items 23a or 28a-f shov event, the Medical Examiner must be notified at 10d. Inside City Limits 10a State 10h County 10c. City, Town or Location death with the Maryland Director 1 X Yes 2 □ No Baltimore MD Baltimore Towson 10g. Citizen of What Country? 10f, Zip Code 10e Street and Number USA 21204 Funeral 25 Ruxview Ct #201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12 Was Decedent Ever in U.S. Armed Forces? Black, White, etc. white 1 Never Married 2 X Married ģ and 2 should be filed within 72 hours after or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene, is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) own home housewife 0 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha Florence Garrett ပ Department of Health and Menta Important: If item 27 is marked any injury or other traumatic evonce. Norman Calvin Bailey 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6451 N. Charles St #361; Baltimore, MD 21212 19a. Informant's Name/Relationship (Type, Print) Robert Ristine - husband 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility State Anatomy Board 21. Signature of Funeral Service Lens Director 655 W. Baltimore St; Baltimore, MD 21201 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examiner Due to (or as a consequence of) attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day 5 Other (specify) 1 Yes 2 9 Unknow cate has been signed by the a page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate has 1 Yes 2 No Yes 2 XIN 25. Was case referred to medical 26. Place of Death (Check only one) funeral director, Be examiner? ASSISTED LIVING FIGUR Other: 1 Yes 2 No 4 Nursing Home 5 Residence 6 Nother (Spe 2 1 Inpatient 2 ER/Outpatient 3 DOA this Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at nours after death.

neral Director: After the filled in by the funeral Certificate: 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours Medical 🔁 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hou

To the Fune

completed fil Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) To the 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MANCH 28 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UMPILVES W TOWSON MD 6701 hunles ST N Day 5 State Registrar

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.

AMEND ITEM#11 Per INF, G914, 4/20/2011, WS

State of Maryland / Department of Health and Mental Hygiene For State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day REGINALD RICKS 04 03 2011 0:00 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner FUTURE CARE BALTIMORE 5. Social Security Numbe 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Min. Months Hours 1 X M 2 🗆 F (Month, Day, Year) 08-07-1964 217-92-0559 Director 46 Yrs Usual Residence of Decedent permit, Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important if item 27 is marked other than "naturo" any injury or other traumatic events. 10h County 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD 1 ▼ Yes 2 □ No BALTIMORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 1019 HARLEM AVENUE 21217 RICKS / REGINALO Baltimore, Maryland 21215-0036 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married ģ Yes 2 X No Yes, Give 1 Yes 2 No Specify Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) TRAIN CONDUCTOR CSX RAILROAD Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ GEORGE S. RTCKS RUTH WASHINGTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) R. HOWARD HILL/BROTHER 4656 PALL MALL RD., BALTO., MD 21215 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 X Cremation 3 - Removal from State 4 Donation 5 Other (Specify) ON-SITE-CREMATORY 4/4/2011 BALTIMORE, MD Synature of Funeral Service Licenses 22. Name and Address of Facility JAMES A. MORTON & SONS F.H. ames 1701 LAURENS ST., BALTO., MD 21217 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last burial-tra Due to (or as a consequence of) attending physician Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 as the IF FEMALE: use 23b. Was decedent pregnan 23d. Date of delivery Live Birth 2 - Fetal death 3 Ectopic pregnancy in the past 12 month jo Month 5 Other (specify) Day Year Pregnant at time of death detached the g ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed þ page 2 should be 2 No 3 Probably 4 Monknown Be Completed peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy certificate 2 No 1 Yes 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) examiner? Hospital 2 WO ျှ 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA irsing Home 5 Residence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred After 1 Natural 5 Pending injury within 24 hours after death.

To the Funeral Director: A M Accident Investigation 6 Could not be 3 ☐ Suicide 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical 29a. Certifier Ecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title 29d. Date signed (Month, Day, Year) ou 0070076 ss of person who completed cause of death (Item 23a) (Type, Print) . Registrar's Signati State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Row A M (ecel1 & 9:50 March 701 Medical 4a. Eacility Name (if not institution, give street and number) or Location of Death 4c. County of Death Examiner 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** (Month, Day, 1 M 2 M Months Davs Hours Min Country) **Director** Usual Residence of Decedent 28a-f shov 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland notified at Completed by Funeral Director 1 Yes 2 No 10g. Citizen of What Country? 10f. Zin Code 10e, Street and Number must be r þ 6722 21201 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S 14. Race - American Indian 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☑ No ō 1 Newer Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Specify 3 ☑ Widowed 4 ☐ Divorced "natural" er than "natur , the Medical I Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Department of Health and Mental Hygiene. Important: If item 27 is marked other tha any injury or other traumatic event, the N once. Be 18. Mother's Name (First, Middle, Maiden Surname) Father's Name (First, Middle, Last, မ 1-ranklin holson ic 19a. Informant's Name/Relationship (Type, rint) Rural Route Number, City or Town, State, Zip Code) Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State St. Edinond's Church 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses an 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Atheroscienatic Cardiovascular DISTULE Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine Due to lor as a consequence of cause. Enter Underlying the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) inding physician use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Other (specify) Pregnant at time of death signed by the af g Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performe 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No Be (26. Place of Death (Check only one) 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After completed filled in by the funer. 1 🗹 Natural work? injury 5 Pending Accident Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier

MSKYGYBML M'D 29c. License number 29d. Date signed (Month, Day, Year) DO057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

S 'Raywalkse MD 2835 Smith A Baltimore, MD. 21709. 31. Date filed (Month) PR 0 5 2011 2. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

James William Riley Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02109 State of Maryland / Department of Health and Mental Hygiene **UNK UNK** Certificate of Death 1. For State Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 17, 2011 2130 hrs Medical Examiner <u>James</u> William Riley 4c County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany Cumberland Queen City Drive If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or UNK 7. Age (In yrs. last birthday) 5. Social Security Number 1111 6. Sex **Funeral** Foreign Country) Months Days Hours Feb 9, 1957 Director 54 1X M 2 F Yrs Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 1 Yes 2 No Allegany Cumberland Pages 1 and 2 should be filed within 72 hours after death with the Maryland neut of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f she or other traumatic event, the Medical Examiner must be notified at once. 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21502 412 Park St. 11. Marital Status unk 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, 8lack, Funeral 12. Was Decedent Ever in U.S. Armed Forces 211 K White, etc. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes Specify: White 1 Yes 2 X No specify: 4 Divorced If Yes, Give Yaar à 16a. Decedent's Usual Occupation (Give kind of work done unk 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) during most of working life. DO NOT use retired) Completed Elementary/Secondary (0-12) College (1-4 or 5+) ltimore, MD 21215-0036 unk unk 18.Mother's Name (First, Middle, Maiden Surname)UNK 17. Father's Name (First, Middle, Last) Be 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

I HOI der Ct. Boonsboro, Md. 2171 MD. 21201 19a. Informant's Name/Relationship (Type, Print) timore O.C.M.E. James Riley- Son 20c. Location - Cify or Town, State 20b. Place of Disposition (Name of cemetery, Date 20a. Method of Disposition crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 4-8-11 Glen Burnie, Md. Important: injury or oth Atlantic Crematory 4 Donation 5 W Other Specify: in State 22. Name and Address of Faelling State Anatomy Board Simplicity Crem. & Fun. Ser. Thomas Allen P.A. 7090 Ridge 21. Signature of Funeral ervice Licen Hanover oproximate inte 23a. Part I. Enter the disease, or a molications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Between Onset and failure. List only one cause on each line /Medical Death Multiple Blunt Force Injury Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and tran 19a-20b,22 per me g914 4-11-11 vt 23a,27,28a-f per me g914 4-15-11 vt Physician/Medical physician at the burial • X AMENDED X UNPENDED Box 68760 23d Date of delivery 23c. If yes, outcome of pregnancy IF FEMALE 23b. Was decedent pregnant in the Month Dav Year 3 Ectopic pregnancy 1 Live birth Fetal death 2 L attending for use as t past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown certificate has been signed by the att rector, page 2 should be detached for 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records, P.O. 仓 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of death? performed Yes 2 No 2 No 1 🗸 Yes 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifi 25. Was case referred to medical Be Other, Nursing Home 5 Residence 6 🗹 Other: Scene Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No ို 28d. Describe how injury occurred 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death subject was a pedestrian Natural 1 Yes 2 X No Division Director: d in by the f 5 Pending fd 3-17-11 Ed 2130hrs struck by a train 2 X Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) Queen City Pavement and Front St. Cumberland. Md filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc Certific 3 6 Could not be Suicide railroad tracks determined (Specify) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. completely Sa 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifie

Olyma

31. Date filed (Month, Day, Year)

APR 0 5 2011

30. Name and address of person who completed cause of death (Item 23a)

Russell Alexander MD.

Assistant Medical Examiner 111

32. Registrar's dignature

111 Penn Street, Baltimore, MD 21201

OCME

March 18, 2011

Registrar

O.C.M.E.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #6% To a Per FH G914 4/07/2011 JH State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2_∧Date of Death 3. Time of Death Physician/ 101 11:56 pm. SHIRLEY RAY Medical Town, or Location of Death 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** N/A eath ave Sex. . Age (In yrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min. 1Most3 Day 9552 MARYLAND 212-56-9320 59 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD. N/A BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 5435 GRADIN AVE. 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces?
1 ☐ Yes 2 ☒ No þ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Specify: BLACK 3 XWidowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry oe filed with. مناط Hygiene. مناط Hyan "r" (Specify only highest grade completed) FOSTER PARE Elementary/Seconday (0-12) College (1-4 or 5+) -Ō--12-PARENT CHILD CARE 2 should be filed with h and Mental Hygien 7 is marked other th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ SHIRLEY MAE CROWDER HENRY C. DRUMWRIGHT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) MARYLAND 21207 KELI RAY (DAUGHTER) 5435 GRADIN AVE. BALTIMORE Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other pl 1X Burjal 2 ☐ Creynation 3 ☐ Removal from State 4-9-2011 BALTIMORE, MARYLAND 4 Donation 5 Other (Specify) of Plineral Service Licen 21. Signat HIBNER^{2. Name and Address of Facility}PHILLIPS FUNERAL HOME, P.A. See JONAT AN 1721 - 27N. MONROE ST BALTIMORE. MARYLAND 21217 Fig. 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death ck, or heart failure. List only one cause on each line. iate Cause (Final Physician/ MYOCARDIAL UTE e or condition hour Medical resulting in death) bue to (or as a consequence of): Examiner 10 years MIHEROSCLEROTIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or iinjury and that initiated events resulting in death) Last burial-trar Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months Month Dav Year 5 Other (specify) Pregnant at time of death signed by the at Id be detached for Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown DIABETES MELLITUS 1 🗌 Yes Completed page 2 should peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an HYPERTENSION has autopsy certificate Yes 2/ e Hospital or Attending Physician: 24 hours after death.
e Funeral Director: After this certificieted filled in by the funeral director, I 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes ည 1 Inpatient 2 ER/Outpatient 3 IDOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of Certificate: 28d. Describe how injury occurred iniury work? 1 Natural Natural
Accident 5 Pending Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Sertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 ho To the Fune completed fi Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗆 only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D 22646 12011 Duy Oin w 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 MARYLAND Jerome 900 SOUTH CATON AVENUE BALTIMORE I. 0 31. Date filed (Month, Day, Year) 32. R State APR O Registrar 5

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DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ , 2011 3 2:00A. Joseph Martin Stachurski April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Timonium Stella Maris 6. Sex 1 M 2 D F Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Days Hours Min October Maryland 212-07-7198 Yrs 18,1916 Director 94 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits with the Maryland notified at Director Md. Balto. Nottingham 28a-f 1 Yes 2 X No 10e. Street and Number 10f. Zip Code ò 10g. Citizen of What Country? must be r Funeral 8908 Kilkenny Circle 21236 USA items Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Examiner Armed Forces? Black, White, etc ō ģ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White If Yes, Give Year or Dates Specify "natural", Completed 3 X Widowed 4 □ Divorced uth and Mental Hygiene. 27 is marked other than "natun r traumatic event, the Medical 2:00 а.ш. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) permit. Page 1 and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any njury or other traumatic event, the Monee. Elementary/Seconday (0-12) College (1-4 or 5+) Martin-Marietta Sheet Metal worker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephen Stachurski Julia Tomaszkiewicz 2011 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DTR. Denise Stachurski 8275 Berryfield Avenue Nottingham, Md. 21236 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State cemetery, crematory or other place) 4-4-2011 Bayview Balto. Md. 21224 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Schimunek Funeral Home 9705 Belair Road Nottingham, Md. 21236 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIOMYOPATHY disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Exami Cause (Disease or impury that initiated events resulting in death) Last To the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-tran attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death JOSEPH STACHURSKI 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No been signed by the atte should be detached for 5 Other (specify) Month Dav Year Pregnant at time of death Part II. <mark>Other significant conditions</mark> contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has blirector, page 2 s performed' Yes 2 X No 2 🗌 No 1 Tyes the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \square Nursing Home 5 \square Residence 6 \blacksquare Other (Specify) **HOSPICE** 힏 2 **X** No 1 Tes 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work?
1 Yes 2 No 28d. Describe how injury occurred 1 X Natural 5 \square Pending 24 hours after death. Funeral Director: A Investigation Accident 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) 29b. Signature and title of cert 29c. License number 29d. Date signed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar 30. Name and address of

Date filed (Month, Day, Year)

JONES.

CRNP

TIMONIUM, MD 21093

2300 DULANEY VALLEY RD.

erson who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 435 PM Physician/ Medical 4a. Facility Name (if no institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore oseda PHA 8. Date of Birth Month, Day, Year, June 19, 1922 9. Birthplace (State or Foreign Country)
New York If Under 24 Hrs. If Under Social Security Number 6. Sex . Age (In vrs. last birthday **Funeral** 1 □ M 2 🗓 F Min. Months Days Hours 88 Director 093-14-6602 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location Director 1 Yes 2 X No Balto. Parkville Md. 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral USA 21234 8820 Walther Blvd. Unit 2107-B Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces 1 Yes 2 No If Yes, Give 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🛣 No Specify. White 3 X Widowed 4 ☐ Divorced Year or Dates 16b. Kind of Business Industry 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Home Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Domenica Iacovone Joseph Dellacroce 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Laurel, Md. 20723 8790 Doves Fly Way Anton Sprissler Son Baltimore, 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of Date cemetery, crematory or other place) 1 🗌 Burial 2 💢 Cremation 3 🔲 Removal from State 4-5-2011 Balto, Md. Bayview 4 ☐ Donation 5 ☐ Other (Specify) Schimunek FuneralHome Signature of Funeral Service Licensee 22. Name and Address of Facility 21236 9705 Belair Road Nottingham, Md,. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ntmed disease or condition resulting in death) Medical Due to (or as Examiner Sequentially list conditions. Physician/Medical Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying burial-transi Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed and that initiated events Due to (or as a consequence of): resulting in death) Last attending physician for use as the burial Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Month Day Pregnant at time of death 2 No signed by the a 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 tonknown Completed been si should I 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has page 2 s performed: 1 ☐ Yes 2 ☐ No certificate Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) ပ္ 1 🗌 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 IDOA this funeral 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: within 24 hours after death.

To the Funeral Director; After completed filled in by the funer injury 1 Natural 5 Pending work? ____ vatural □ Accident □ S 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 [within 2. only one 29d. Date signed (Month, Day, Year) 29b. Signature and title of 10 30 Name and address of person who completed cause of death (Item 23a) (Type, Print) Jul Th 8800 MININITA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 3:50 A M Clara Virginia Szeliga Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Gilchrist Towson 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours Min June 8, 1 🗆 M 2 🔀 F Maryland 1921 **Director** 220-14-9635 89 Usual Residence of Deceden 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 72 hours after death with the Maryland Examiner must be notified at Director 1 Yes 2 X No Howard Woodstock Maryland 0 10f. Zip Code 10e. Street and Numbe 10g. Citizen of What Country? 23a Funeral United States 10629 Breezewood Drive 21163 items 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. ō, 1 Never Married 2 Married Completed by 1 ☐ Yes If Yes, Give 2 X No Maryland 21215-0036 1 ☐ Yes 2X No Specify: 3 Divorced Specify: "natural", White Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental | Important: If item 27 is marked of any injury or other traumatic eve ပ္ Clara Nelson Howard Schaff 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10629 Breezewood Dr. Woodstock, MD 21163 Louis Szeliga / Husband Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place 1 ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Final Journey Crematory 4/2/2011 Woodbine, Maryland 22. Name and Address of Facility
Going Home Cremation Service P.O. Box 784
Beverly L. Heckrotte, P.A. Clarksville, MD 21029 21. Signature of Funeral Service Lice Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart dailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ 200 disease or condition Medical resulting in death) Due to (or as a onsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) and I-transit Exam Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last attending physician for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Pregnant at time of death 9 Unknown s been signed by the should be detached P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed? Yes 2 No page 2 this certificate has death? 1 ☐ Yes 2 ☐ No Division of Vital 24 hours after death.
• Funeral Director: After this certific leted filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 2 No Other: 1 Yes ဂ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 NOther (Specify) NOSOLU 28a. Date of injury (Month, Day, Year) 27. Manner of Dea h 28b. Time of 28c. Injury at 28d. Describe how injury Certificate: 1 Natural
2 Accident
3 Suicide 5 Pending injun 1 Yes 2 No M Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined building, etc. (Specify) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 24 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AARON M HARVES N. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** Simmons, Arthur 3:55 AM APRIL 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** Johns Hopkins Bayview Medical Center **Baltimore** 5. Social Security Number If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex 1 X M 2 □ F 7. Age (In yrs. last birthday) **Funeral** Months Days 217-38-5856 69 **Director** Baltimore, Maryland August 12, 1941 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Item 27 is marked other than "nature!" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Maryland 1 Yes 2 No Director **Baltimore** Dundalk 10e. Street and Number 10f. Zip-Code 10g. Citizen of What Country? 41 Shipping Place Apt B5 21222 United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces
1 Xes 2 If Yes, Give
Year or Dates: Black, White, etc. 1 Never Married 2 Married 2 🗆 No 1 ☐ Yes 2 No Specify White 2 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4 or 5+) Sheet Metal Worker Sessa Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Frederick A. Simmons, Sr. Genie Genevieve Savchuk ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Arthur S. Simmons, Jr. (Son) 8465 Sand Point Drive Jacksonville, Florida 32244 20b. Place of Disposition (Name of cametery, crematory or other place

Evans Funeral Chapel—

Bel Air 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 X remation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland 21. Signature of Funeral Service Licensee

22. Name and Address of Facility
Evains: Funeral Chapel & Cremation
3 Newport Drive Forest Hill, Ma

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hardfailure. List only one cause on each line.

Immediate Caus in nal disease or condition 22. Name and Address of Facility
Evalue: Funeral Chapel & Cremation Services Bel Air
3 Newport Drive Forest Hill, Maryland 21050 Approximate Interval Between Onset and Death ORONARI **Physician** disease or condition resulting in death) 30 yeas /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Box 68760. Physician/Medical 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 3 T Ectopic pregnancy 2 Fetal death in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) 2 ☐ No Division of Vital Records, P.O. 9 I Unknown 9 Unknown ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? ğ 1 🗌 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 NO 2 🗍 No Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA မ after death.

Director: After this
d in by the funeral d this 27. Manner of Death 1 ☑ Natural 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation Injury 1 Yes 2 No 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide the Funeral Director of the Fu Hospital 1 Vertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES-DOO

State Registrar

31. Date filed (Month, Day, Year)

MD

32. Registrar's Signature

ORIGINAL

4940 Eastern Avenue, Baltimore, MD, 21224

APR 0 5 2011

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month March Physician/ 2011 1:00 P M Normalee Ruth Summers Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Anne Arundel Yellow Springs South Laurel 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral Social Security Number Age (In vrs. last birthday) Days (Month, Day, Year 1 □ M 2 🖾 F Months Hours Min. Maryland Director 212-26-9318 June 5, 80 Usual Residence of Decedent show 10d. Inside City Limits ral", or items 23a or 28a-f sho Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland Director 1 🗆 Yes 2 😾 No MD Anne Arundel Laurel 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? Funeral USA 20724 3396 Yellow Springs South 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify. Specify: White "natural" 3 Widowed 4X Divorced Year or Dates and 2 should be filed within 72 hours Health and Mental Hygiene. tem 27 is marked other than "natur other traumatic event, the Medical I 16a, Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Funeral Home Ø Greeter 8th Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Ruth Creighton Crumbacker Jesse 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3396 Yellow Springs South, Laurel, MD Mary Johnson/Daughter item 2 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4/4/2011 Laurel, MD 4 Donation 5 Other (Specify) MD National Mem. Pk 22. Name and Address of Facility Donaldson Funeral Home, P.A. 21. Signature of Funeral Service Licenses 313 Talbott Avenue, Laurel, MD 20707 M01103 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician. Chronic Obstructive Pulmonary Disease vrs disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed and Due to (or as a consequence of): resulting in death) Last burialattending physician Physician/Medical Division of Vital Records, P.O. Box 68760 the as IF FEMALE for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Day Month Year Pregnant at time of death Unknown be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Hypertension 1 X Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Renal Failure 24a. Was an autopsy performed? Yes 2 K No has page certificate 1 ☐ Yes 2 🛛 No Be 25. Was case referred to medical 26. Place of Death (Check only one) funeral director Hospital Other: 4 Nursing Home 5 K Residence 6 Other (Specify) 2 🕅 No မ 1 Yes 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 28b. Time of 27. Manner of Death 28c. Injury at Certificate: injury 1 X Natural 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No ☐ Accident☐ Suicide Investigation the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier D0047707 April 1, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DV 20707 Rita Pabla, MD 13621 Baltimore Avenue, Laurel, MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

05

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Physician/ Day 2011 РΜ April 6:08 Sander Barbara Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Linthicum Heights Tate Hospice If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** Country)
Maryland (Month, Day, Year) 1 □ M 2 🗓 F Director Yrs 214-44-2211 Apri Usual Residence of Decedent "natural", or items 23a or 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 72 hours after death with the Maryland traumatic event, the Medical Examiner must be notified at Director 1 Yes 2 No Anne Arundel Maryland Pasadena 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21122 7824 Linthicum Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S 11. Marital Status Armed Forces?
1 ☐ Yes 2 🗓 No Black, White, etc. by 1 Never Married 2 K Married 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: 3 Widowed 4 Divorced White Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) N/A permit. Page 1 and 2 should be filed within in Department of Health and Mental Hygiene. Important: If item 27 is marked other than David Edward LTD Customer Service Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Miller Elliott, Sr Evey1n Edwin William 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7824 Linthicum Road Pasadena, Maryland 21122 Roger J. Sander (Husband) injury or other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 Cremation 3 Removal from State 04/06/2011 Glen Burnie, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Pk. ^{22. Name and Address of Facility}
McCully-Polyniak Funeral Home, P.A.
3204 Mountain Road Pasadena, Maryland 21122 21. Signature of Funeral Service Licensee any 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ Medical Due to (or as a consequence of) **Examiner** as Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of) nding physician and use as the burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnam 9 ☐ Unknown Yes Unknown Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Silenot's Cardio Vonubern 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed' death? 1 Yes 2 No 1 ☐ Yes 2 🗷 25. Was case referred to medical examiner? Division of Vital Be 26. Place of Death (Check only one) Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Hospital 2 No 1 🔲 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural 5 Pending 1 Yes 2 No within 24 hours after death.

To the Funeral Director: A completed filled in by the fu Investigation Accident 2 Accident
3 Suicide
4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the I within 2. only one 29b. Signature and title 29d. Date signed (Month, Day, Year) rson who completed cause of death (Item 23a) (Type, Print) 10 3,708 mountain Rd, Pasadena, MD21122 eBoris State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. AMEND ITEM# ITERFH, G914, 4/12/2011, WS State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 201 Tarch /Medical 4b. City, Town, or Location of Death 4c. County of Death Facility Name (If not institution, give street and number) **Examiner Baltimore City** The Johns Hopkins Hospital Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 5. Social Security Number 6. Sex Hours **Funeral** Days 1 □ M 2 🔀 F 06/27/1960 50 142-52-3198 Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a. State 10b. County show must be notified at 1 ☐ Yes 2X No Director Toms River ŊJ Ocean 28a-f 10g. Citizen of What Country? 10f, Zip-Code 10e. Street and Number ŏ U.S.A. items 23a 08753 543 Fountain Drive Funeral Pages 1 and 2 should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Race - American Indian Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) "natural", or iten 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Completed 16b. Kind of Business/Industry 15. Decedent's Education th and Mental Hygiene.

I is marked other than "natun traumatic event, the Medical (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) Transportation Special Needs Bus Attendant 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Elizabeth Iannacone John Colegrove ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 543 Fountain Dr., Toms River, NJ 08753 of Health Riccardo G. Sindoni Sr. item 27 other t 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any Injury or once. <u>-</u> გ 4/7/11 Toms River, NJ St. Josephs Cem. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatu 22. Name and Address of Facility Kedz Funeral Home 1123 Hooper Ave., Toms River, NJ 08753 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) onar /Medical Examiner Sequentially list conditions, if cause. Enter Underlying Cause (Disease or injury that initiated events Examine Due to for as a consequence of physician and s the burial-transit or Attending Physiclan; The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 \subseteq Live birth 2 \subseteq Fetal death 23d. Date of delivery 23b. Was decedent pregnant Live birth 3 Ectopic pregnancy Month Vear in the past 12 months?
1 Yes 2 No Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed to þ 3 Probably 4 Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy ate has page 2 2 No 2 No 1 Yes certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital 2 100 2 ER/Outpatient 3 🗌 DOA 1 Yes Inpatient မ Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Natural Certification: 5 Pending investigation Injury 1 Yes 2 No Accident Director: A 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) City or Town, State; 4 Homicide within 24 hours a To the Funeral L Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier RES-000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Steven 600 North Wolfe St, Baltimore, MD, 21287 MP 32 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 05 Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygieney for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day 2011 :36 AM Josephine Kirby Stallings Abril Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner N/A Baltimore 5924 The Alameda Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Country) Maryland 1 🗆 M 2 🗶 F Months Days Hours Min. 10-21-1935 215-34-1945 75 Director Usual Residence of Decedent 28a-f show 10b. County 10a. State 10d. Inside City Limits iral", or items 23a or 28a-f sho Examiner must be notified at 10c. City. Town or Location Director Baltimore 1 X Yes 2 No N/A Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA Funeral 21239 5924 The Alameda Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Tes 2 X No Specify: permit. Page 1 and 2 should be filed within 72 hours aft Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", any injury or other traumatic event, the Medical Exar Specify Completed 3 Widowed 4 Divorced White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Seconday (0-12) Banking Administrative Secretary 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Edgar D.Kirby Margretta D. (Unknown) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3030 Iona Terrace Baltimore, Maryland 21214 19a. Informant's Name/Relationship (Type, Print) Mrs. Elizabeth Kirk - Representative 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Hilltop Service Corporation 04-07-2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) nature of Funeral Service Licenses 22. Name and Address of Facility 5305 Harrford Road Leonard J. Ruck, Inc. Baltimore, Maryland 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final cardiomyonath lated Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** CO Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine pue to lor as a consequence on and that initiated events resulting in death) Last Due to (or as a consequence of) use as the burialphysician Physician/Medical requires that the death certificate be bivision of Vital Records, P.O. Box 68760 the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 1 ☐ Yes ∠ y 9 ☐ Unknown Unknown care nas been signed by to page 2 should be detach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by fibrillation, Pempheral vasculon 1 Yes 2 No 3 Probably 4 Unknown this certificate has been cellulitis, chronic renal insufficience Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed 7 death? 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 ☐ Yes 2 No Hospital: Other: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After injury 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation upleted filled in by the 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certif 30. Name and address of person who completed gause of death (Item 23a) (Type, Print)

PAMELA LIN, MD 7801 YORK 7801 YORK Pamela #102 TOWSON 31. Date filed (Month, Day, Year, 32. Registrar's Signature State APR 0 5 2011 Registrar

K DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time Day Physician/ Medical 4a. Facility Name if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Co. Middle River 336 Shagbark Road 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday, **Funeral** ,1943 Month, Day, Y 1 □ M 2XXF Months Hours Min. Mary Land Director 213-38-8652 67 June Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; If item 27 is marked other than "nother "nother than 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 Yes 2 No Middle River MD Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21220 United States 336 Shagbark Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married ☐ Yes 2 🔀 No Yes, Give þ ☐ Yes 2 No Specify. Completed 3 → Widowed 4 □ Divorced White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Self Employed Waxman Corp. 10 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Bernice Lee Huff Arthur Franklin Spitler 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 336 Shagbark Road Middle River, Maryland 21220 Ms. Robin L. Mixter(Daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 🗵 Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/2/2011 Towson, Maryland 4 Donation 5 Other (Specify) Signature of Fundal Service Lio Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Dundalk, Maryland 7922 Wise Ave. 23a. Part 7. Enter the disease, or complications that caused the shock, or heart failure. List only one cause on each line. r the mode of dying, such as cardiac or respiratory arrest, Approximate Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) (or as a consequence of) Due t Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Day Year Month Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown After this certificate has been si funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 1 Yes 2 No Yes 2 No To the Funeral Director: After this certifica completed filled in by the funeral director, I Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DCA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 Yes 2 🗌 No Accident Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a To the Funeral D Medical 1/2 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 3 30 (Type, Print) 30. Name and address of person who completed cau SCHROEVER 705 DIGITAL DR. LINTHIWM Signature State Registrar

DHMH 17 Rev 7/2009

Tyrone Slay 11-02489

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

	State of Maryland / Department of He 1-For State Registrar Certificate of De	aath	2011 10845 Reg. No.								
Physician/ Medical Examiner	1. Decedent's Name (First, Middle,Last) 2. Date of Death Month Day Year March 31, 2011										
)	4a. Facility Name (if not institution, give street and number) 4b. C	ity, Town, or Location of Death	4c. County of Death								
Funeral Director	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) ff 217 - 94 - 2703 1 X M 2 F 31 Yrs.	Birth (MM/DD/YYYY) 9. Birthplace (State or Foreign Country) MD									
4 403	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location		10d. Inside City Limits								
the Maryland or 28a-f sho Hifted at once.	MD NA Baltimore 10e. Street and Number 10f	. Zip Code	1\(\frac{1}{X}\) Yes 2 No No 10g. Citizen of What Country?								
ith the Maryland 23a or 28a-f sho notified at once	1441 Meridene Drive 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec	21239 cedent of Hispanic Origin? (Specify Yes or I	USA								
15-0036 filed within 72 hours after death with the Maryland Hygiene. ch the than "natural", or items 23a or 23a-f she the Medical Examiner must be notified at once a Completed by Funeral Director	Never Married 2 Married Armed Forces? If Yes, s	pecify Cuban, Mexican, Puerto Rican, etc.) 2 No specify:	white, etc. African specify: American								
hours aft natural" Examine											
5-0036 led within 72 hour 1/1/2 giene. other than "natu the Medical Exan Completed	10th Grade NA Unempl	•	Unemployed								
Q 5 5 5 Q	17. Father's Name (First, Middle, Last) Tyrone Slay	18.Mother's Name (First, Middle Ti Juan	Parker								
D non in it		ress (Street and Number or Rural Route Neridene Drive Ba									
	1 X Burial 2 Cremation 3 Removal from State Crematory or other pl	(Name of cemetery, lace) Pk. 04-05-1	1 timore, MD 21239 20c. Location - City or Town, State Randallstown, MD								
Baltimore, oemit. Pages I ar Department of Hei Important: If ite injury or other tr	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee 22. Name	Funeral Home P.A.									
Physician	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the more failure. List only one cause on each line.	Baltimore Md 21217 arrest, shock, or heart Approximate Interval Between Onset and									
/Medical Examiner	Immediate Cause (Final disease or condition resulting in death) a. Gunshot Wound to Head Due to (or as a consequence of):		Death								
<u> </u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of):										
ted Insit	cause. Enter Underlying Cause (Uisease or injury that initiated events resulting in death) Last Due to (or as a consequence of):										
execular and and and and and and and and and and	d. UNPENDED AMENDED										
6876 certifica nding ph se as the	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Da 23d. Date of delivery Month Da 1 Ves 2 No 9 Unknown 9 Unknown										
i, P.O. Bries that the disigned by the I be detached dispersed by the between dispersed by Physical By	Part II. Other significant conditions contributing to death but not resulting in the under		tobacco use contribute to the cause of death? 'es 2 V No 3 Probably 4 Unknown								
Division of Vital Records, P.O. Box To the Hospital or Attending Physician: The law requires that the death within 24 hours after death. To the Fuoeral Director: After this certificate has been signed by the attercompletely filled in by the funeral director, page 2 should be deathed for usedical Certification: To Be Completed by Physic			as an 24b. Were autopsy findings available prior to completion of cause of death?								
ital Recition: The scentificate rector, page	25 Was case referred to medical		2 No 1 Yes 2 No								
of Vita	examiner? 1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 27. Manner of Death 28a. Date of Injury 28b. Time of Injury		Residence 6 Other:								
tion of vitending Photestics: After tive funeral vite funeral vite funeral sation: T	1 Natural 5 Pending Mar 31, 2011 1402 hrs	1 Yes 2 ✓ No Subject sh									
Division o opital or Attending tours after death. oeral Director: Aft filled in by the fime Certification:	3 Suicide 6 Could not be determined (Specify) Street	or Town	28f. Location (Street and Number or Rural Route Number, City or Town, State) 6000 Moravia Park Drive, Baltimore, Md.								
To the Hos within 24 ho within 24 ho completely completely ledical (29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred a cone 2 Medical Examiner:On the basis of examination and/or investigation, in and manner stated.										
A S P S W	29b. Signature and title of certifier	29c. License number O.C.M.E.	29d. Date signed (Month, Day, Year) April 1, 2011								
	30. Name and address of person who completed cause of death (Item 23a)										
	Ling Li, MD Assistant Medical Examiner 111 Penn Street, B 31. Date filed (Month, Day, Year) 32. Registrar's Signature	attiniOre, IVID 2 1201									
Registrar DHMH 17 Rev 1/2001	APR 0 5 2011 Augus J. Jack	OCME									

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** CHARLES SEDEWICK 1254 PM 1105, APRI /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner NA The Johns Hopkins Hospital **Baltimore City** If Under 1 Year If Under 24 Hrs. 8. Date of Birth
Months Days Hours Min. (Month, Day, Year)
07-03-63 Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 XM 2 □ F Yrs 47 215-84-5640 MD Director Usual Residence of Decedent Maryland 10d. Inside City Limits 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryle Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 1 X Yes 2 □ No Director Baltimore MD Randallstown 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 9000 Bruno Road 21133 USA Funeral Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11 Marital Status Black, White, etc. African 1X Never Married 2 Married 1 Tyes 2 TXNo Baltimore, Maryland 21215-0036 1 ☐ Yes 2X XNo þ If Yes, Give Year or Dates: Specify Specify: American 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) 10th Grade ÑΑ Disabled Disabled 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Sedgwick, Sr. Ruth Tyler ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 211339000 Bruno Road Randallstown, Maryland Terry Sedgwick-Sister 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 XBurial 2 Cremation 3 Removal from State 04-04-11 Randallstown, MD King Mem. Pk. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Wylie Funeral Home P.A. 638 N. Gilmor Street Baltimore, MD 21217 Luer 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HOART FAILURE **Physician** CONGESTIVE /Medical Due to (or as a consequence of) Examiner ARDIOMYOPATH. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner YPERTENSION Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) nding physician Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death
4 Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Year 5 Other (specify) 2 No Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 Yes 2 □ No မ 27. Manner of Death 28a. Date of Injury 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: 5 Pending investigation (Month, Day Year) 1 Natural 2 Accident Director: Af 1 Yes 2 No 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, determined 4 - Homicide City or Town, State) 24 hours a 29a. Certifier X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. one) within 2

To the I

comple 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number APRIL 2, 2011 D0035468 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -IANG HORACE 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, Year) 32. Register's Signature State barker Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 2011 2, Albert 8:20 PM Salamone Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death OakCrest Care Center Parkville Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 27, 9. Birthplace (State or Foreign **Funeral** 1 X M 2 D F Hours Months Min 99 Baltimore, MD Director 212-07-0378 1912 Jan. Usual Residence of Decedent 28a-f show 10a. State 10b. County notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No MD Baltimore Parkville 10e. Street and Number 10f. Zip Code ö 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a once. Funeral 8820 Walther Blvd. #4214 21234 USA 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 42 -46 1 ☐ Yes 2 🕅 No Specify: 3 X Widowed 4 Divorced Specify: White Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) N/A Elementary/Seconday (0-12) 12 Insurance Broker Insurance Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Pauline Dongarra Salvatore Salamone 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard A. Salamone/Son 18802 Fox Chase Ct. Parkton, MD 21120 20a. Method of Disposition 20b. Place of Disposition (Name of April Date 6 20c. Location - City or Town, State Dulaney Valley Memorial Gardens 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 2011 Timonium, MD Signature of Funcion Service Livensee 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley,
10 W. Padonia Road Timonium, MD 21093 Inc. Flagle Michael J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Pneumoni Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of the burial-tran that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Box 68760 for use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Year Pregnant at time of death 5 Other (specify) Dav 2 🔲 No 9 Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by pe 1 Tes 2 No 3 Probably 4 Unknown Dementia completed filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 No 24a. Was an nas autopsy To the Hospital or Attending Physician: 25. Was case referred to medical Division of Vital Be 26. Place of Death (Check only one) examiner? 2 No Other: Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 5 Pending injury Investigation 6 Could not be Accident 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier R067343 TOT e of death (Item 23a) (Type, Print) PAAKville, M. 21234 WALTHER BIVd. 32. Registrar's Signature APR 0 5 2011 State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Day Month Herbert Wayne Smith Apri 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 110 Rhineforte Drive Churchville Harford 9. Birthplace (State or Foreign Country)
Virginia Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Funeral 7. Age (In vrs. last birthday) Year) 933 1 🖾 M 2 🗆 F Months Days sept. 4 **Director** Yrs. 227-42-4076 77 Usual Residence of Decedent 10a State ms 23a or 28a-f sho must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 💆 No Maryland Harford Churchville 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Rhineforte Drive 21028 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Completed by 1 Never Married 2 M Married 1 X Yes If Yes, Give 2 No Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates d Mental Hygiene. marked other than "natur matic event, the Medical I 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Lineman Electric Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Hagar (unk) Smith Ethel (unk) Amburn and N 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health tem 27 Betty Jane Smith / Spouse 110 Rhineforte Drive, Churchville, MD 21028 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Nother (SpecifyEntombment 4-5-11 Bel Air, Maryland Memorial Gdn 22. Name and Address of Facility
McComas Funeral Home, P.A. 21. Sign ture of up ral Service Licensee 1317 Cokesbury Rd., 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset and Death Ph_sician/ CARdio ATherosciencino disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Dus to (or as a consequence or). attending physician and for use as the burial-transit Due to (or as a consequence of) resulting in death) Last Physician/Medical P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy **To the Funeral Director:** After this certificate has been signed by the atter completed filled in by the funeral director, page 2 should be detached for a in the past 12 months? Day Year Pregnant at time of death 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 \square Yes 2 \square No 3 \square Probably 4 \bowtie Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 24 hours after death.

Funeral Director: After this certificate has autopsy performed? Yes 2 2 No 2 **No** 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: 2 🖪 No ျှ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred Hospital or Attending 1 M Natural 5 Pending Accident 1 Tes 2 No Investigation 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 1 🗓 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 🗌 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 🗀 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 13552 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) NORTH BEL

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

5 2011

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			Registrar 1. Decedent's Name (First, Middle, Las	t)						2. Date of De	ath		3. Time of Death			
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	Funeral Director		219-34-1897		Year 1938 Maryland											
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	or 28	直	10e. Street and Number	OLG	1003	ALL	10f. Z	ip Code			10g. Ci	itizen of What	Country?			
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			For State Registrar		R	10850								
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- A	Examin	er	4a. Facility Name (if not institution Southern Maryla	nd Hospital			Clinton	Location of Death			ce Geo	rge's		
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	yland -f show ed at	ctor	Usual Residence of Decedent 10a. State 10b. County Maryland Prince	George's	10c. City, To	wn or Loc nton	cation			10d. Inside City Limits 1 ☐ Yes 2XXNo				
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920	o filed within 72 hours after death with the Maryland Hygiene. A Hygiene. And Hygiene. A do they than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	by	 11. Marital Status 1 ☐ Never Married 2 ☐ Mar 3 ☒ Widowed 4 ☐ Divorced 	Armed Forces? 1 Yes 2		If		n, Mexican, Puerto			etc. te			
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ore	Page 1 and ment of Heal ant: If item 3 ury or other		20a. Method of Disposition 1 ☐ Burial 2XX Cremation 4 ☐ Donation 5 ☐ Other (3 Removal from State		of Dispos etery, crem	sition (Name of natory or other plac	ce)	Date					
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68760	ertifical ding ph	/Me	IF FEMALE:	23c. If yes, outcome	of pregnancy					204 5	ata of doli			
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P.O.	ires that the dea signed by the a Id be detached f	by Pr	Part II. Other significant conditi	ons contributing to death t	out not resultin	g in the u	nderlying cause gi	ven in Part I.	./		tribute to	the cause of death?		
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Vita	ysicia is cert direct	To Be	exammer? 1 🗌 Yes 2 🗌 No	Hospital:	ient 2 🗆 ER/	Outpatier	Oth	er:	ome 5 🗆 Resid	ence 6 🗆 Ot	her (Speci	fy)		
n of	nding Ph tth. ; After thi e funeral	Certificate:	27. Man er of Death 1 Natural 5 Pendi 2 Accident Invest	ng 28a. Date of inju	ury 28t y, Year)	o. Time of injury	work		28d. Describe ho	ow injury occu	rred			
Division of Vital	Hospital or Attending Physician: The law requires that the 24 hours after death. Funeral Director: After this certificate has been signed by the sted filled in by the funeral director, page 2 should be detach		3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern			farm, stre	eet, factory, office			28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_	To the Hospital or within 24 hours after To the Funeral Dire completed filled in the state of th	Medical	(Check 2 Medical	g Physician: To the best of Examiner: On the basis of e g Nurse Practioner: To the	examination and	d/or invest	tigation, in my opini	on, death occurred a	at the time, date ar	nd place, and d	ue to the c	ause(s) and manner stated.		
_	To the vithin 2 To the comple	~	29b. Signature and title of certifie		1	7	29c. Licens			29d. Date sign				
	21		30. Name and address of person	who completed cause of	death (Item 23a	a) (Type, F	Branch	Ave C	linton.	No	20	735		
ľ	Sta		31. Date filed (Month Day Year)	5 2011 32. Fegistr	ar's Signature		Parkel			,				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

AMEND ITEM#1perPHYS, G914, 4/7/2011, WS

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) Stanley M. Stascavage 2. Date of Death 3. Time of Death Physician/ Stanley M. Staccauage 2011 10:38 P M 2. April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Charlotte Hall St. Mary's Charlotte Hall Nursing Home 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1**X**M 2 □ F Months Days Hours (Month, Day, Yea Country) 91 Director 207 01 9882 Nov 11 1919 Penn Usual Residence of Decedent or 28a-f show 10a, State 10b. County er than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗆 Yes 2 🔁 No MD Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Completed by Funeral 7710 Mike Shapiro Drive United States 20735 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian, Was Decedent Ever III 0.3.
Armed Forces?
1 ☑ Yes 2 ☐ No 1940—1961
If Yes, Give Black White etc. 1 Never Married 2 Married 3altimore, Maryland 21215-0036 White 1 ☐ Yes 2 X No Specify. 3 X Widowed 4 □ Divorced Specify. Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Linguist U.S. Air Force should be filed with and Mental Hygien Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ည Kate Burns Ludwick Stascavage and 2 should b Health and Mer tem 27 is mark 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ellen Smith (Daughter) 7710 Mike Shapiro Drive, Clinton, MD 20735 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) unk Arlington, VA <u> Arlington National Cemeterly</u> 21. Signature of Funeral Service Licensee MO1558 22. Name and Address of Facility Lee Funeral Home, Inc 6633 Old Alexandria Del Ferry Road, Clinton, MD 20735 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ CARDIAC ARRHYTHMIA disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner FAILURE HEART ONCESTIVE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed ARTERY DISEASF CORONARY and-trans that initiated events Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death 5 Other (specify) Month Day Year 1 Yes 2 9 Unknown been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by KIDNEY Records, DISEASE CHRONIC 1 ☐ Yes 2 🗹 No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page 2 Jas autopsy performed death? certificate 1 Yes 2 No Yes 25. Was case referred to medical Hospital or Attending Physician: director, Be 26. Place of Death (Check only one) examiner? 2 No 1 Yes Other: ည 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA this funeral 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28h Time of 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: After the function of the functin 2 Accident
3 Suicide 1 Tes 2 No Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 only one 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MD D0067788 4.3.2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 29449 Charlotte Hall Road, Charlotte Hall, MD 20622 KDDALI 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 7/2009

P.O. I

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April 201 T Flora Virginia 9:20 P M Shuey 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Marley Neck Health & Rehabilitation Glen Burnie Anne Arundel Social Security Numbe 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 1 🗆 M 2 🗓 F June 23, 1924 Days Hours Country) 218-14-4901 86 MD Usual Residence of Decedent 10a. State 10d. Inside City Limits 10c. City, Town or Location MD Brooklyn Anne Arundel 1 X Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 Washburn Avenue 21225 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: White 3X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Roy Wesley Haines Laura Virginia Kircher 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Carolyn Bashman /Daughter 764 Evergreen Road Severn Maryland 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Glen Haven Mem. Park Glen Burnie, MD agnature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral & Cremation Services PA 1 2nd Ave. SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Physician/ Medical Examiner

Physician/

Medical

Director

Funeral

Completed by

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Examiner

Funeral

Director

28a-f show

permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-transit isigned by the ail has within 24 hours after death.

To the Funeral Director: After this certificate filled in by the funeral director,

To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760

Medical Certificate: To Be Completed by Physician/Medical Examiner

29b. Signature and title of

30. Name and address of

Immediate Cause (Final disease or condition resulting in death)	Caed	uc An	rettoma				Onset and Death					
resulting in death)	Due to (or as a conseq	uence of):										
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that initiated events resulting in death) Last	Due to (or as a conseq											
IF FEMALE:												
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Part II. Other significant conditions con	r 11	,	g cause given in Part I.				o the cause of death?					
Dembo	·				24a. Was an autopsy performed?	prior to	itopsy findings available completion of cause of					
25. Was case referred to medical examiner?			26. Place of Death	h (Check or	nly one)							
1 Yes 2 No	lospital: 1 Inpatient 2	ER/Outpatient 3	DOA Other:	rsing Home	5 Residence	6 Other (Spec	cify)					
27. Manner of Death 1 Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year)	28b. Time of injury	28c. Injury at work? 1 Yes 2	1	d. Describe how inju	ury occurred						
3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specif		ory, office	28	f. Location (Street a City or Town, Star		ral Route Number,					
(Check 2 Medical Examin	cian: To the best of my know ler: On the basis of examination Practioner: To the best of m	n and/or investigation,	in my opinion, death occ	curred at the	e time, date and place	ce, and due to the	cause(s) and manner stated					

DHMH 17 Rev 7/2009

State Registrar

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		For State Registrar			riale of N	iai yiai i					Death			Reg. No	241		10853
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Funeral Director		5. Social Security N 213-76-5	lumber	6. Sex	2 ∏ F 7. F		If Under Months	_	If Under Hours		8. Date of Bi (Month, D Mar 4,	f Birth 9. Birth			place (State or Foreign ntry) Land		
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e Mary 8a-f sh	Director	MD		Hagerstown										1 □Yes 2 □ No			
3a or 2	al Dir	10e. Street and Nur 11814 Pa				10f. Zip	Code	2174	2		10g. Cr		What Cou SA	ntry?			
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at once.	by Funeral		arital Status ☐ Never Married 2 Married ☐ Widowed 4 ☐ Divorced 12. Was Decedent Armed Forces? 1 ☐ Yes 2 Married If Yes, Give Year or Dates:					If Yes, specify Cuban, Mexican, Puerto Rican, etc.)								ck, White,	can Indian, etc. nite
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and 2 sh dealth and im 27 is n		19a. Informant's Name/Relationship (Type. Print) Donald Shinham/spouse 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, 11814 Partridge Trail Hagerstown, MD 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Date 20c. Location											MD	21742			
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The law requir cate has been s page 2 should	Completed							-		-		_		opsy formed?		. Were aut prior to c death? 1 ∐Yes	topsy findings available completion of cause of
sician s certifi irector,	Be	25. Was case refer examiner? 1 ☐ Yes 2 ☑		-	pital:	atient 2	I ED/Outo	ationt	3 [] [V	Oth	or.		th (Check only		6 FT0	thos (C	
rding Physician: The th. th. After this certificate has funeral director, page	tion: To	27. Manner of Deat 1 ☑ Natural 2 ☐ Accident	th 5 ☐ Pendi	ing tigation	28a. Date of I		28b. Tin Inju	ne of		8c. Injur Worl			ome 5 Res				ary)
To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu	Certification: To	3 ☐ Suicide 4 ☐ Homicide	6 □ Could deter	I not be mined	28e. Place of building,	njury - At h etc. <i>(Speci</i>	lome, farm	n, street	t, factory	, office			28f. Location City or To	(Street a	and Num te)	nber or Ru	ral Route Number,
the Hospital hin 24 hours a the Funeral I mpletely filled	edical (29a. Certifier (Check only one)				s of examin							e, and due to the				stated. to the cause(s)
To th withir To th comp	Me	29b. Signature and	title of certifi		^ 0				290		e number		-	29d. Date signed (Month, Day, Year)			
		30. Name and add		S 1 S	berg :	f death (Ite	m 23a) (T	ype, Pri	int)	54	Pn/	1 P	laie	6	Salt	ירטין	, WD 21223
Sta Registr		31. Date filed (Mon		011	\$2. Regi	strar's Sign	ature	Me	,								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 10854 State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ MARCH 29 5:45 A M STRAUSS 2011 JACQUELINE Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY 4701 WILLARD AVENUE, APT. 1122 CHEVY CHASE 5. Social Security Number 7. Age (In vrs. last birthday) If Under 1 Year 6. Sex If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country)
 CANADA **Funeral** 1 □ M 2 🗓 F Months Hours M2707711927 CANADA **Director** 176-20-0396 83 Usual Residence of Deceden ral", or items 23a or 28a-f show Examiner must be notified at 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 72 hours after death with the Maryland Director 1 Yes 2 X No MONTGOMERY CHEVY CHASE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 4701 WILLARD AVENUE, APT. 1122 20815 USA "natural", or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify. 3 Widowed 4 X Divorced WHITE Completed Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 1 and 2 should be filed within 72 of Health and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the VICE PRESIDENT FINANCE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည TOBY DANIEL STEIN SARAH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11654 PLAZA AMERICA DRIVE, #734, RESTON, VA MARJORIE MYERS/EXECUTOR 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of I
Important: If ite
any Injury or ot
once. 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) BALTIMORE HEBREW CEM: 04/04/2011 REISTERSTOWN, MD Signature of Funeral Service Lic-inso 22. Name and Address of Facility SOL LEVINSON & BROS., INC. selicell 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death 2009 shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) ANGIOSARCOMA (L) BREAST Medical Due to (or as a consequence of) Examiner BREAST CANCER 1994 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ng physician and as the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) ____ Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month Day Year Pregnant at time of death detached the ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? b should be HYPERTENSION 1 Yes 2 No 3 Probably 4 Unknown Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an ABDOMINAL AORTIC ANEURYSM The law page 2 s has autopsy performed? Yes 2X N certificate 1 Yes 2 No or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical To Be 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 1 Yes 2X No 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28d. Describe how injury occurred 28c. Injury at (Month, Day, Year) 1 XNatural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Hospital Medical 1 🖔 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 🗍 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 03/29/2011 DC5496 Name and address of person who completed cause of death (Item 23a) (Type, Print) Street, NW, Washington, DC 31. Date filed (Month State 5 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 10:10 A M Turk Marian Annette Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Cockevsville Broadmead If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In vrs. last birthday) **Funeral** 91 Days Hours Min. 1/14/1920 Delaware 1 🗆 M 2 😾 F 222-07-0030 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 72 hours after death with the Maryland ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 Yes 2 No Cockeysville Baltimore Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number Funeral U.S.A. 21030 #320 13801 York Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2X No If Yes, Give Year or Dates White 3 X Widowed 4 Divorced "natural", the Medical 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Page 1 and 2 should be filed within 72 ment of Health and Mental Hygiene. ant: If item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker other traumatic event, Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Anna Hamilton Marion Callaway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15120 Jarrettsville Pike Monkton, Maryland 21111 Michael R. Medinger / Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a Department of H Important: If ite any injury or ot 1 Burial 2XI Cremation 3 Removal from State Hilltop Service Corp 4/7/2011 Towson, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 21. Signature of Fineral Se 1050 York Road Towson, Maryland 21204 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ ONG disease or condition resulting in death) Medical Examiner Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of sician and burial-trans that initiated events Due to (or as a consequence of) resulting in death) Last physician Physician/Medical use as the the attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Pregnant at time of death After this certificate has been signed by the a funeral director, page 2 should be detached 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 12 No 3 Probably 4 Dunknown 1 Yes Division of Vital Records, DIABETES MELLITUS 24b. Were autopsy findings available 24a. Was an autopsy performe prior to completion of cause of death? 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director, After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Wursing Home 5 Residence 6 Other (Specify) ည 27. Mann f Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d. Date sighed (Month: Day, Year) 383 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 12 Registrar's Signature 31. Date filed (Month, Day, Year) State APR 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Phillip Trombetta Bonaventure 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Baltimore** Towson Manor Care Dulaney 8. Date of Birth (Month, Day, Year) Feb. 21, 1914 If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, Months Days Hours **1**√ M 2 □ F Maryland 97 Feb. 215-07-4319 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2√ No Timonium Baltimore Maryland | 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number U.S.A. 21093 Jody Way 14. Race - American Indian 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married

1 ☐ Yes 2 ☐ No

(Give kind of work done during most of working life. DO NOT use retired)

22. Name and Address of Facility

caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line.

3 ☐ Ectopic pregnancy 5 ☐ Other (specify) __

3 □ DOA

CertifyIng Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in a control of the cause (s).

Ave

Other:

1 □ Yes 2 □ No

H0054424

28c. Injury at Work?

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

Mary

16a. Decedent's Usual Occupation

Meatl Worker

319 Jody Way 20b. Place of Disposition (Name of cemetery, crematory or other place)

St. Stanislaus Cem.

hera

ue to (or as deconsequence of):

Due to (or as a consequence of):

Due to (or as a consequence of):

23c. If yes, outcome pf pregnancy

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

1 Inpatient

28a. Date of Injury (Month, Day Year)

and manner stated

2 ER/Outpatient

28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify)

Dundalk

32. Registrar's Signature

28b. Time of

Injury

1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death

abetes

Specify:

18. Mother's Name (First, Middle, Maiden Surname)

Vito

Timonium, Maryland 21093

Ruck Towson Funeral Home, Inc. Towson, Md. 21204

24a. Was an autopsy performed? 2♥No

4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)

Dundalk, MD 21222

28d. Describe how injury occurred

1□ Yes

26. Place of Death (Check only one)

19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)

Date

4/5/11

16b. Kind of Business/Industry

Steel Industry

20c. Location - City or Town, State

Dundalk, Maryland

23d. Date of delivery

Day

24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No

Month

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City or Town, State)

29d. Date signed (Month, Day, Year)

1 Yes 2 No 3 Probably 4 Unknown

1050 York Road

White

/Medical $\mathbb R$ Division or Vital Records, P.O. Box 68760, $\mathbb R$

Examiner Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and director, this After after death in by the within 24 hours a To the Funeral I the 2

1 - For State Registrar

Physician

/Medical

Examiner

Funeral Director

2

Completed

Be

ျှ

Examiner

Physician/Medical

þ

Completed

Be

Certification: To

Medical

State

Registrar

319

3√ Widowed 4 Divorced

Elementary/Secondary (0-12)

Bonaventure

20a. Method of Disposition

Immediate Cause (Final

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

23b. Was decedent pregnant

in the past 12 months? 1 ☐ Yes 2 ☐ No 9 Unknown

25. Was case referred to medical examiner?

29b. Signature and title of certifier

31. Date filed (Month, Day, Year)

5 Pending

investigation

determined

6 ☐ Could not be

Asadi

1 Yes 2 No

27. Manner of Death

1 Natural
2 Accident

3 ☐ Suicide

29a, Certifier

4 Homicide

disease or condition resulting in death)

17. Father's Name (First, Middle, Last)

21. Signature of Funeral Ser ice Lic

au

19a. Informant's Name/Relationship (Type. Print)

23a. Part1. Enter the disease, or complications in shock, or heart failure. List only one cause

Dolores P. Delorenzo / Niece

1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)

8 yrs.

15. Decedent's Education (Specify only highest grade completed)

College (1-4or 5+)

Trombetta

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 23 to marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mcdical Examiner must be activated once.

Physician

Baltimore, Maryland 21215-0036

DHMH 17 Rev 1/2001

10

Beneva B. parks

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

3029

Hospital:

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 7:00 AM Marilyn Jean Vest Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c, County of Death **Examiner** Anne Arundel Harwood Mandrin House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days 1 🗆 M 2 🔀 F Hours Min. Auq 20, Maryland 1958 **Director** 52 217-72-7043 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is anarked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 Yes 2 X No Millersville Maryland Anne Arundel 10f. Zip Code 10g. Citizen of What Country? Funeral 21108 United States 111 Sandgate Court 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 X No Specify Specify: White 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home should be filed with h and Mental Hygien 7 is marked other th Homemaker 10 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Mary Louise Alexie Donald John Stempinski 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sandgate Ct. Millersville, MD 21108 Mary Stempinski / Mother Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 X Cremation 3 Removal from State Final Journey Crematory 4/5/2011 Woodbine, Maryland 4 Donation 5 Other (Specify) Going Home Cremation Service P.O. Box 784 Beverly L. Heckrotte, P.A. Clarksville, MD 21029 MO1251 23a. Part 1. Enter the pisease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of): Exami certificate be executed Cause (Disease or linjury that initiated events and -trar Due to (or as a consequence of): resulting in death) Last attending physician a for use as the burial-Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death
9 ☐ Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy • Hospital or Attending Physician: The law requires that the death c 24 hours after death.
• Funeral Director. After this certificate has been signed by the atter leted filled in by the funeral director, page 2 should be detached for u. in the past 12 months?

1 Yes 2 No Month Dav Year 5 Other (specify) 9 Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 📈 Yes 2 □ No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe Yes 2 2 No ☐ Yes)92d 110 Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 \(\sum \) Nursing Home 5 \(\sum \) Residence 6 \(\sum \)Other (Specify) 2.00 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 17🗖 Natural injury work? 5 Pending 2 🗀 No 2 Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifier Date signed (Month, Day, Year) and address of person who con noleted cause of death (Item 23a) (Type, Print) 55 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 _ For State Certificate of Death 1, Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Vincent Joseph Anthony 2011 10:20 PM March Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Co. Gilchrist Hospice Center Towson 5. Social Security Number 8. Date of Birth (Month, Day, Year) May 11, 1918 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 1 XM 2 | F Days Min Months Hours Maryland 92 Director 213-07-3542 Usual Residence of Decedent 28a-f show 10a. State 10b County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director notified Dundalk Baltimore 1 Yes 2X No MD 5 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? must be Funeral 23a 21222 United States 6610 North Point Road 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. Armed Forces? 5 þ 1 Never Married 2 X Married 1 XYes 2 No permit. Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify "natural", 3 Widowed 4 Divorced Completed White Year or Dates WWII th and Mental Hygiene.
27 is marked other than "natur traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed, (Give kind of work done during most of working life. DO NOT use retired) Patapsco & Back River Elementary/Seconday (0-12) College (1-4 or 5+) Railroad Locomotive Engineer 12 Years Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Anna Chicy F. Vincent Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zi 1161 Ikena Circle Honolulu, HI 96821 t of Health Mr. Thomas C. Gorak (Nephew) other 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 0 1 Burial 2 Cremation 3 Department of Important: If any injury or once. Hilltop Service Corp. 4/5/2011 Towson, Maryland 4 Donation 5 Other (Specific P. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. in 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused shock, or heart failure. List only one cause on each line , or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ sheimer Dementea disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) nsit that initiated events resulting in death) Last ng physician and as the burial-tra Due to (or as a consequence of): Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 been signed by the attending should be detached for use as IF FEMALE 23b. Was decedent pregnant Live Birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 Ŵio 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 ☐ No Yes 2 N 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 Mo Other: ျ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 □ Nursing Home 5 □ Residence 6 🗷 Other (Specify) No3 P (4 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide Hospital or Attending 5 Pending after death.

Director: After in by the fur 1 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours 29a. Certifie Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Sia and title of certifier 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) WHANES W) 6701 N. 31. Date filed (Mo State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death . 2011 2011 Physician/ Nadine Eugenia Williams 8:00 P.M 01 April Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore County Hunt Valley 1202 Mapleleaf Court 9. Birthplace (State or Foreign 5. Social Security Number Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** 1 □ M 2 🏝 F Months Hours 513-10-9895 92 May 05, 1918 Coldwater Kansas **Director** Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location death with the Maryland notified at Director 1 Yes 2 No Baltimore County Hunt Valley Maryland 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò ms 23a or must be n 21030 United States Funeral 1202 Mapleleaf Court ural", or items ? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S. 11. Marital Status Armed Forces?
1 ☐ Yes 2 XNo Black, White, etc 1 Never Married 2 Married þ filed within 72 hours after Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify: If Yes, Give Year or Dates Specify: White "natural", 3 ₺ Widowed 4 □ Divorced Completed Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) th and Mental Hygiene.

27 is marked other than traumatic event, the Me Elementary/Seconday (0-12) $\overset{\text{College }(1\text{--}4 \text{ or }5\text{+})}{N/A}$ Home Maker Own Home Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked oth any injury or other traumatic event once. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Mildred Harmon Nat Barnes 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Hunt Valley, Maryland 21030 1202 Mapleleaf Court Mr. Donald C. Williams (Son) 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State (Harford County) cemetery, crematory or other place)
Evans Funeral Chapel and
Cremation Services, Inc. 1 Burial 2 Cremation 3 Removal from State Monday, 4 ☐ Donation 5 ☐ Other (Specify) Forest Hill, Maryland April 04,2011 21. Signature of Funeral Service Ligensee Jeffrey L. Gair, Sr. 22. Name and Address of Facility
Peaceful Alternatives Funeral and Cremation Center, P.A. Jan, 1 Lic.#M00677 Timonium Maryland 2325 York Road 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death MONTG(Immediate Cause (Final P i ian/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury been signed by the attending physician and should be detached for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>\$</u> 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed? 1 ☐ Yes 2 ☐ No eral Director: After this certificate Ifiled in by the funeral director, pag 25. Was case referred to medica 26. Place of Death (Check only one) B B examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 은 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work?
1 Yes 2 No 1 Natural 5 Pending hours after death Investigation Accident 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) within 24 hours a To the Funeral I Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) B/a(110000 J950n 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Tou son MS 21200

State Registrar

DHMH 17 Rev 7/2009

31. Date filed (Month, Day, Year)

APR 0 5 2011

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Department of Certificate of Death Reg. No. 1, Decedent's Name (First, Middle, Last) 2 Date of Death waltemeyer Month | Physician/ 10.338M Joseph Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical alen Brinie Center Annde Anne Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth Funeral 1 X M 2 🗆 Davs Hours Min. (Month, Day, Year) Country)
Maryland **Director** 215-50-5244 Tine 62 Usual Residence of Decedent or 28a-f show 10b. County 10d. Inside City Limits 10a. State 10c. City, Town or Location Examiner must be notified at Director 1 Yes 2 No Maryland Anne Arundel Glen Burnie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? items 23a Funeral 1718 Saunder Way 21061 within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces?

1 Yes 2 No Black, White, etc. than "natural", or þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify. If Yes, Give Year or Dates 3 Widowed 4 Divorced Completed White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) N/A and Mental Hygiene. Allied Signal Engineer permit. Page 1 and 2 should be filed wi Department of Heaith and Mental Hygi Important: If item 27 is marked other any injury or other traumatic event, I Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ellison Waltemeyer Pear1 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Joshua A. Waltemeyer (Son) 1718 Saunder Way Glen Burnie, Maryland 21061 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Cremation 04/05/2011 Glen Burnie, Maryland 21. Signature of Funeral Service Licenses 22 Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death I Zh Durs Immediate Cause (Final disease or condition Physician/ Ventricular Medical resulting in death) Due to (or as a consequence of) Examiner Ischemie Sequentially flet conditions if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examine Cause (Disease or iinjury that initiated events Chronie To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) resulting in death) Last physician a s the burial-1 Division of Vital Records, P.O. Box 68760 🕳 Physician/Medical Hypertension attending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year 2 No signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should Directiculosis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? Yes 2 No 1 ☐ Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: Other: 1 Yes 2 🔀 No 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) ပ this 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 28b. Time of 24 hours after death.
Funeral Director: After the 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the F 3 🗌 only one) 29b. Signature and title of certifier D56950 Y WY STRIAN 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)-1411 Madison Onve Snite IL Glen Brrnie garely Nnaemeka Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 DULLY 1:15 PM WILLIAM 2011 Medical Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hospital secours If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🕱 F Months Days Hours 214-20-8904 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10h County filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12 ington Ave Apt 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Black Specify: Completed 3 Widowed 4 Divorced Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) . Page 1 and 2 should be filed within 72 tment of Health and Mental Hygiene. tant: If item 27 is marked other than 'jury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) 12 th Grade edica Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Inknown 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Apt#2 14321 West Way Lane Dale City VA 22193 Son 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State permit. Page 1
Department of
Important: If it
any injury or o 1 Burial 2 Cremation 3 Removal from State Park Gremater 4 Donation 5 Other (Specify) 04-4-2011 Riverdale . Signature of Funeral Service Licenses 22. Name and Address of Facility 814 upshur St Services 23a. Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one Immediate Cause (Final Coronary Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by onia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No this certificate 2 🗷 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, I To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 ANO Other: 1 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 27 Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 🗹 Natural 5 Pending 1 Yes 2 No Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check To the within 2 only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) HYSICIAN 3-30-11 Name and address of person who completed cause of death (Item 23a) (Type, Print) PREETIMOGR IN. BALTIMORE 940 BALTIMURE, MD 21223 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Robyn Weeks Ach 201 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 6. Sex 7. Age (In yrs. last birthday) If Under 24 Hrs **Funeral** 8. Date of Birth 9. Birthplace (State or Foreign Month, Day, Year 07-18-8 1 - M 2X-XF Months Days Hours Min Director 29 Yrs 212**-11-**6570 MD Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Madical Examiner must be notified at 10a, State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore XX Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2509 Lauretta Avenue 21223 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. African Armed Forces? þ 1 X Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Divorced Specify: American Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Unemployed Unemployed 10th Grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ഉ Melvin Weeks, Sr. Earleen Wilson 19a. Informant's Name/Relationship (Type, Print) Mother 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Earleen Wilson Ball 911 N. Warwick Avenue Baltimore, MD 21216 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20c. Location - City or Town, State 1 🖔 Burial 2 🗆 Cremation 3 🗆 Removal from State 04-07-11 Lansdowne, MD 4 ☐ Donation 5 ☐ Other (Specify) Signature of Funeral Service License 22. Name and Address of Facility Wylie Funeral Home P.A. 638 Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ povolemia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) been signed by the attending physician and should be detached for use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Pregnant at time of death 5 Other (specify) Month Day Year 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Liver failure, 1 ☐ Yes 2 🔀 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has I completed filled in by the funeral director, page 2 s autopsy performed? Yes 2 No 2 🗆 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital 2 No Other: ပ 1 Yes 1 Npatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, 27. Manner of Death Certificate: Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) Natural 5 Pending injury Accident
Suicide
Homicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined building, etc. (Specify) Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated, 23 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) Signature and title of certifier 29c. License number 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Year)

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day WILKIN Physician/ Medical 4a. Facility Name (if not institution, give street and number) Examiner SECOURS 8. Date of Birth (Month, Day, Year 01-22-5 Sex XXM 2 □ F If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** 217-56-5118 60 Director Usual Residence of Decedent 28a-f shov 10d. Inside City Limits 10a. State 10c. City, Town or Location ral", or items 23a or 28a-f sho Examiner must be notified at Director 1 X Yes 2 No MD NA Baltimore 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? USA 903 N. Rosedale Street 21216 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Black, White, etc.African Armed Forces?

1 Yes 2 No ģ 1 X Never Married 2 Married "natural", or Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes Give Specify: American 3 Widowed 4 Divorced Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me Elementary/Seconday (0-12) 12th Grade College (1-4 or 5+) NA University Hosp. Custodian 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Johnson Sylvia Wilkins Ernest 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 903 N. Rosedale Street Baltimore, MD 21216 Sylvia Burley-Mother 20b. Place of Disposition (Name of cemetery, crematory or other place)
Mt. Zion Cem. 20a. Method of Disposition 20c, Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 04-08-11 Lansdowne, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Wylie Funeral Home P.A. 21. Signature of Funeral Service License 638 N. Gilmor Street Baltimore, MD 21217 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate interval Between Onset and Death ACUTE RENAL FAILURE Immediate Cause (Final Pnysician/ disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury AIDS attending physician and for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?

1 Yes 2 No
9 Unknown Month Year Pregnant at time of death signed by the a Hospital or Attending Physician: The law requires that the 24 hours after death.
Funeral Director: After this certificate has been signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? OBSTRUCTIVE PHIMONALY DISTIE Completed by CHRONIC 1 Yes 2 No 3 Probably 4 Unknown been si should b CACHEXIA 24b. Were autopsy findings available prior to completion of cause of death? MALNUTRITION 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 🕱 No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: 4 \(\text{Nursing Home} \) 5 \(\text{Residence} \) 6 \(\text{Other} \) Other (Specify) Inpatient 2 ER/Outpatient 3 DOA ျ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of injury 28c. Injury at 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation completed filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the l within 2 To the l only one) U. M ophbeli, MD 0149 49 BALTIMORE, MD 2170 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

Registrar

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien State Registrar Certificate of Death 1. Decedem)'s Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Montk 5:18p. M Medical Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 4202 Wentworth Road Baltimore If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, . Social Security Number 7. Age (In vrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Hours 1 M 2 - F Country) Director 214-56-7639 60 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at death with the Maryland 10a. State 10b County 10c. City, Town or Location 10d. Inside City Limits Director MD NA Baltimore 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21207 4202 Wentworth Road U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1. Marital Status 12. Was Decedent Ever in U.S. 14. Bace - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 Yes If Yes, Give 2 X No 72 hours after Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: Black 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) giene. Elementary/Seconday (0-12) College (1-4 or 5+) 10th grade Construction Worker Centra Maintaine Co. 17. Father's Name (First, Middle, Last) Unknown Be 18. Mother's Name (First, Middle, Maiden Surname) should be file and Mental F Inez Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 and 2 s if Health in 4202 Wentworth Road, Baltimore, Md 21207 Carrollyn Ward-Wife Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or otl Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) 4/7/2011 Memorial Park Woodlawn, Md 21. Jign ture of Funeral Service Licensee 22. Name and Address of Facility
March F/H West 4300 Wabash Ave. Baltimore, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause or the line. Approximate terval Between Immediate Cause (Final nset and eath Physician/ disease or condition Medical resulting in death) to (or as a c sequeno Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a constituence law requires that the death certificate be executed and -trans that initiated events resulting in death) Last Due to (or as a consequence of) /sician a Physician/Medical Box 68760 phys the k attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery in the past 12 ponths? 3 Ctopic pregnancy
5 Other (specify) Month Pregnant at time of death Day Year ed by the a detached f 9 I Unknown 9 Unknown P.O. s been signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 3 Probably 4 Unknown No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of has autopsy page perform death? Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No Yes 2 25. Was case referred to medical **Division of Vital** funeral director, Be 26. Place of Death (Check only one) Hospital: 2 No Other: 1 Yes ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending nours after death.

neral Director: Af
I filled in by the fur 2 Accident 1 Yes 2 No Investigation 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within To the 29b. Signature and title of certifi 29d. Date signed (Month, Day, Year) who completed ca 31. Date filed (Month, Day, Year) State 5 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death John - F. Williams, Jr. Physician/ 3:27A March 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 514 Hawthorne Road Anne Arundel Linthicum Heights 7. Age (In vrs. last birthday) Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🛛 M 2 🗆 F 219-66-9575 Days Dec. 9, 1953 Hours **Director** Maryland Usual Residence of Decedent show 10a. State 10c. City, Town or Location 10d. Inside City Limits Director must be notified 28a-f MD Anne Arundel Linthicum Heights 1 🗌 Yes 2 🌁 No 10e. Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral 23a iled within 72 hours after death with 514 Hawthorne Road 21090 United States 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Medical Examiner Armed Forces?
1

Yes 2 □ No 0 Black, White, etc. ģ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 ☐ Yes 2 No Specify: "natural", If Yes, Give Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education Decedent's Usual Occupation 16h. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) traumatic event, the Electrician Electrical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked ပ John F. Williams, Sr. Mary Sobotka and is m 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 Hawthorne Road Linthicum Heights, MD 21090 item 27 Mary Williams / Mother or other 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o once. 1 🛣 Burial 2 □ Cremation 3 □ Removal from State Meadowridge Mem. Park Apr. 2,2011 Elkridge, Maryland 4 Donation 5 Other (Specify) 22. Name and Address of Facility Ambrose Funeral Home, Inc. 1328 Sulphur Spring Road Arbutus, MD 21227 25a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Cancer Physician/ Larungeal Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exami Cause (Disease or linjury the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of): attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death use 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No ō Month 1 Yes 2 Unknown the 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by þe 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed certificate 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify, this ieral Director; After th filled in by the funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Matural 5 Pending 2 Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State within 24 hours a

To the Funeral C

completed filled Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
4 Certifying Physician: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) MS RijapalneM·D D0057465 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1835 Smish N-5-203, Balhmore, MD 21209 N-S-Rajapakse,M.D R 0 5 2011 32. Registrar's Signature State Registrar

N DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 2, 2011 John Weber, Jr. 12:55 P M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Edenwald Towson 5. Social Security Number | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Au Month, Pay, Year 09 Funeral 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 1 X M 2 □ F Mary Land Director 101 214-03-4930 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 X No Marvland Baltimore Towson 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 509 Piccadilly Road U.S.A. 21204 "natural", or items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11, Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Ves 1943-1945

If Yes, Give 1943-1945 1 Never Married 2 Married Black, White, etc. <u>ک</u> Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: 3 X Widowed 4 □ Divorced Specify: Completed Year or Dates White and 2 should be filed within 72 hours Health and Mental Hygiene. tem 27 is marked other than "natur ther traumatic event, the Medical I 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Installation & Service Mgr. Major Oil Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Weber, Sr. Gertrude Harner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Douglas H. Albrecht Friend 8007 Harris Avenue Baltimore, Maryland 21234 permit. Page 1 and 2 Department of Health Important: If item 2 any injury or other t 20b. Place of Disposition (Name of Dulanew of Tage) Place)
Memorial Gardens 20a. Method of Disposition 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4-7-2011 Timonium Maryland ^{22. Name and Address of Facility}Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, MD 21204 21. Signal vie of Funeral Service License Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 23a. Part 1. Enter the disease, or complications Approximate Interval Between Myoca Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Ordenying Physician/Medical Examiner Due to (or as a consequence of) Cause (Disease or linjury that initiated events resulting in death) Last attending physician and for use as the burial-tran Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be ewithin 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicia Division of Vital Records, P.O. Box 68760 IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Day 2 No 1 ☐ Yes 2 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Yes 2 ☑ No Other: မ 1 Inpatient 2 ER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation Suicide 3 Suicide
4 Homicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MO suwe, 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes 10868 For State Registrat Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Anne McCracken Watts 2011 12:45 a^M <u>March</u> Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** 330 Wende Way Anne Arundel Co. Glen Burnie Social Security Number 8. Date of Birth (Month, Day, Year) 07/06/194] 9. Birthplace (State or Foreign Country)
New York If Under 1 Year | If Under 24 Hrs. . Age (In yrs. last birthday) **Funeral** Min Days 1 🗆 M 2 💢 F 69 216-40-7043 Director Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2X No MD Glen Burnie Anne Arundel 10e. Street and Number 10g. Citizen of What Country? Funeral 330 Wende Way 21061 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Completed 3 Widowed 4 Divorced Specify: White Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ William Miller McCracken Amelia Dorothy Frees 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Davidson C. Watts/ Husband 330 Wende Way Glen Burnie, MD 21061 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 34 hours after death Division of Vital Records, P.O. Box 68760

	4 Donation 5 Other (Spec	ify) Meadow	ridge Mem.	Park 04/04	4/2011	Elkridge	, MD				
	21. Signature of Funeral Service Licen	XWVE MOILING		^{ress of Facility} Sin PA; 1 2nd			Cremation ie, MD 21061				
dical Examiner	23a. Part 1. Enter the disease, or conshock, or heart failure. List only of limmediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last	a. Due to or as a consequence of the total pure to or as a consequence of the consequenc	Sclerosis	_	r respiratory arrest,	113	Approximate Interval Between Onset and Death 15 Years 2 weeks				
by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 🕅 No 9 ☐ Unknown	23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3	ncy		23d. Date of de Month	slivery Day Year				
Completed by Pl	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the first significant conditions contribute to the first significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the first significant conditions contribute to the first significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the first significant conditions contrib										
	25. Was case referred to medical		0.0	Disease of Death (Charle	1 🗆 Yes 2 🔏		s 2 🗆 No				
To Be	examiner? 1 Yes 2 No	Hospital:	01	Place of Death (Check	me 5 X Residence	C	-26.)				
Certificate: T	27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation	28a. Date of injury (Month, Day, Year) 28b. T	ime of 28c. Injury wo		28d. Describe how inj		ary)				
	3 ☐ Suicide 6 ☐ Could not I 4 ☐ Homicide determined		m, street, factory, office	,	28f. Location (Street a City or Town, Sta		ıral Route Number,				
Medical	(Check 2 Medical Exam	ysician: To the best of my knowledge, c niner: On the basis of examination and/or rse Practioner: To the best of my knowle	r investigation, in my opii	nion, death occurred at	the time, date and pla	ice, and due to the	cause(s) and manner state				
	29b. Signature and title of certifier			se number	29d. I	Date signed (Mont	h, Day, Year)				
	6 day siles	cup	1	118354		131/2011					
	30. Name and address of person who Amy Schuler	completed cause of death (Item 23a) (7		t Pasado	na, mi	2(122					
te ar	31. Date filed (Moids, Day, Year) APR 0 5 20		bares	, , , , , , , , , , , , , , , , , , , ,							
09											
		OR	IGINAL								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death Physician/ Medical 4a. Facility Name (if not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Randallstown Northwest Hospital 5. Social Security Numbeunk If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept 27, 9. Birthplace (State or Foreign Country unk 7. Age (In yrs. last birthday **Funeral** Min Hours 1 🕅 M 2 🗆 F 64 Months 1946 Yrs **Director** Usual Residence of Decedent 28a-f show 10c. City, Town or Location $\,{
m unk}\,$ 10d. Inside City Limits "natural", or items 23a or 28a-f sho edical Examiner must be notified at 10a. State 10b. County unk with the Maryland Director $\mathsf{unk}_{\mathsf{1}\;\square\;\mathsf{Yes}\;2\;\square\;\mathsf{No}}$ MD 10f. Zip Codeunk 10e. Street and Number unk 10g. Citizen of What Country? USA Funeral Page 1 and 2 should be filed within 72 hours after death incrent of Health and Mental Hygiene.

Tant: If item 27 is marked other than "natural", or items lury or other traumatic event, the Medical Examiner mulany or other traumatic event, the Medical Examiner mulans. 12. Was Decedent Ever in U.S. Armed Forces?unk Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Statusunk Black, White, etc. δ 1 Never Married 2 Married 1 Yes 2 If Yes, Give Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. 3 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation unk 16b. Kind of Business Industryunk Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Be 18. Mother's Name (First, Middle, Maiden Surname) unk 17. Father's Name (First, Middle, Last)unk ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) un19a. Informant's Name/Relationship (Type, Print) Alexander Fenwick - friend 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or ott 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 🕅 Other (Specify) in state 22. Name and Address of Facility State Anatomy Board Signature of Funeral Servic Licenses Ronald S. Wade Director 655 W. Baltimore St; Baltimore, MD 21201 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Priysician/ disease or condition resulting in death) Medical Due to (or as consequence of Examiner Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) Exami Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): attending physician I for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Day Pregnant at time of death Yes been signed by the should be detached 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an cate has b page 2 sl autopsy performe death? certificate 1 🗆 Yes 2 🔀 2 No within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ho ပု 1 Yes 2 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 27. Manner of Deat 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: Natural injury 5 Pending 1 Yes 2 🗌 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of certifier ၉

State Registrar 30. Name

and address of person

APR 0 5 201

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician/ Day JAMES BERNARD WATKINS, JR 1:25p^M MARCH Medical 4a. Facility Name (if not institution, give street and number) 21208 Examiner 4b. City, Town, or Location of Death 4c. County of Death hmort 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Country) MARYLAND Months Hours (Month Day Ye 1 M 2 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits traumatic event, the Medical Examiner must be notified at Director 28a-f MD. BALTIMORE PIKESVILLE 1 XYes 2 No 10e Street and Number ö 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 1450 BEDFORD AVE. APT 718 21208 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. P ð 1 Never Married 2X Married 1X Yes If Yes, Give 2 🗆 No Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: BLACK "natural", Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 hand Mental Hygiene.
7 is marked other than "n Elementary/Seconday (0-12) College (1-4 or 5+) -6-FOOD Be 17. Father's Name (First, Middle, Last) Department of Health and Mental h Important: If item 27 is marked any injury or and in 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ JAMES B. WATKINS SR. JEANETTE WILLIAMS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) APT 718 MARTHA L. WATKINS (WIFE) 1450 BEDFORD PIKESVILLE, MARYLAND 21208 Baltimore, 20a. Method of Disposition 1 Burial 2 Crer 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place) Cremation 3 - Removal from State 4 Donatic 5 (Specify) ¢ARRISON FOREST VETERANS 4-8-2011 OWINGS MILLS. MARYLAND HIBNI-R22. Name and Address of Facility PHILLIPS FUNERAL HOME, P.A. Signatu al Service icenses ONATH D 1721-27 N. MONROE ST. BALTIMORE, MARYLAND 21217 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock for heart failure. List only one cause on each line. Interval Between Onset and Death Immedia e Cause (Final disease condition resulting in death) Physician/ Medical Due to (or as a consequence of) Examiner o pristute cancer Sequentially list conditions Examine if any, reading to immediate cause. Enter Underlying Cause (Disease or iinjury attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Box 68760 IF FEMALE: yes, outcome of pregnancy
Live Birth 2 D Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atte in the past 12 months? Month Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown P.0. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No has 1 Yes 2 No To the Hospital or Attending Physician: I within 24 hours after death.

To the Funeral Director: After this certifics completed filled in by the funeral director, t Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital Other: 1 🗌 Yes 2 No ဂ္ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural (Month, Day, Year) 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) cause of death (Item 23a) (Type, Print State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Amend Items 25,30 per dr.,g914,04/05/2011dhb Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death wilson Month 03 Day 2 8 Year 1 Physician/ Mary 0805AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Randallstown Baltimore Center Randallstown 5. Social Security Numbe If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days Min. 1 M 2 TF Hours 3Month, 1938ar) Country) 75/rs 216-42-2050 Director Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director 1 Yes 2 No Baltimore Gwynn Oak 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2009 Woodlawn Drive, Apt. D 21207 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, 11. Marital Status Black, White, etc. ģ 1 Never Married 2 Married ☐ Yes 2 No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2√2 No Specify Specify: African-American 3 Widowed 4 □ Divorced Completed permit. Page 1 and 2 should be filed within 72 hour. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "naturany injury or other traumatic event, the Medical any injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Aide Sol Tuffok Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Bessie Commander Isaac Boone 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2009 Woodlawn Drive, Apt. D, Gwynn Oak, MD 21207 19a. Informant's Name/Relationship *(Type, Print)* Ethel LIsbon/Sister 20b. Place of Disposition (Name of cemetery, crematory or other place)
King Memorial Park Method of Disposition 20c. Location - City or Town, State Date 1X Burial 2 Cremation 3 Removal from State 4-2-2011 Woodlawn, MD 4 Donation 5 Other (Specify) Wylie Funeral Home F.A. of Balto. Co. Signature of Funeral Service Licensee 22. Name and Address of Facility 9200 Liberty Road, Randallstown, MD 21133 23a. Part 1 there the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Renal Pnysician/ Stage failure. End disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Corenar Sequentially list conditions, Due to (or as a consequence oi). Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Peripheral ending physiciar and use as the buricl-transit Vas cular that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical or Attending Physician: The law requires that the death certificate be angrene Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Day Year Pregnant at time of death 9 Unknown Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? nellitus Diabetes 1 ☐ Yes 2 🖾 No 3 ☐ Probably 4 ☐ Unknown Hypertension 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? Yes 2 No certificate has Hyper Lipidemia 1 Yes 2 No ours after death.

eral Director After this certific filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 10 2 🔀 No Hospital: Other: 4 X Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 🔀 Natural 2 🔲 Accident work? 1 ☐ Yes 2 ☐ No 5 - Pending Investigation 3
Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospita 24 hours Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed within 2 To the I Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. L.BOYOS IMP D71493 3/28/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar

32. Registrar's Signature

Bozorgi, 9109 Liberty Road, Randallstown, MD 21133

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 2011 Robert E. 8:45 A^M Young Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 938 Imperial Court Halethorpe Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Months Hours Min July 19, 1930 80 Director 218-26-1311 Ohio Usual Residence of Decedent or 28a-f show notified at 10c. City. Town or Location filed within 72 hours after death with the Maryland 10d. Inside City Limits **Funeral Director** 1 ☐ Yes 2 X No Halethorpe Maryland Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ŏ or than "natural", or items 23a of the Medical Examiner must be 21227 United States 938 Imperial Court Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 XYes 2 No
If Yes, Give
Year or Dates. Black, White, etc. 1948-1952 Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry al Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Bread Delivery Salesman t. Page 1 and 2 should be filed wit trment of Health and Mental Hygie rtant: If item 27 is marked other ' njury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Earl Henry Young Iola Sarah Warner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sherry Young / Wife 938 Imperial Court, Halethorpe, Maryland 21227 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Tremation 3 Removal from State permit. Page Department o Important: If any injury or once. 04/06/2011 Baltimore, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Metro Crematory Inc. 21. Signature of Funeral Service Licensee Alyson K Taylor 22. Name and Address of Facility Cremation Society of Maryland ALA 299 Frederick Rd., Baltimore, Maryland 21228 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final ENCEPHALOPATHY META BOLIC Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** CUTE RENAL HAILURE Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): BACTEREMIA the Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit PNEUMO ATA that initiated events resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy
4 Pregnant at time of death 5 Other (specify) ____ 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year Day 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by NODULE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 💆 Unknown CANCER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? cate has GAMMOPATHY MONOCLONAL performed? Yes 2 No within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, pag 2 🗌 No 25. Was case referred to medica 26. Place of Death (Check only one) 2 No Hospital: Other: 2 1 Tes 4 Nursing Home 5 N Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29c. License number 0058580 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Name and address of person who completed cause of death (Item 23a) (Type, Print) B21. BOWLE, MD. 32.33 SUPERIOR LN, B21. BOWLE, MD State Registrar

DHMH 17 Rev 7/2009

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	0 1 N D		29b. Signature and t					1		29d. Date signed (Month, Day, Year) 4/4/11				
	the F the F mplet	Me	only one) 3	Certifying Nur	se Practioner: To the	best of my	knowledge, de	eath occurred at the	ne time, date and	place, and due to the	ne cause(s) and	manner as st	ated.	
۵ :	tospital 4 hours a uneral L ed filled	dical (29a. Certifier 1 (Check 2	Certifying Phy	sician: To the best of	my knowle	edge, death oc	ccured at the time	e, date and place	e, and due to the ca	ause(s) and mai	nner as state	d. use(s) and manner stated.	
Division of Vital	to the trospital or Attending Prysician: The lawithin 24 hours after death. To the Funeral Director: After this certificate he completed filled in by the funeral director, page	Medical Certificate:	2 Accident 3 Suicide 4 Homicide	Investigatio 6 Could not be determined		ıry - At hor :. <i>(Specify)</i>	me, farm, stree		Yes 2 No	28f. Location (: City or Tox		nber or Rural	Route Number,	
of '	After thi funeral (ate: 1	27. Manner of Death 1 XNatural	5 Pending	28a. Date of inju (Month, Day	ry :	28b. Time of injury	28c. Inju wor	ry at k?	28d. Describe I				
Vita	lysiciar is certif directo	To Be	examiner? 1 \sum Yes 2\forall		Hospital: 1 🔀 Inpati	ent 2 🗆 E	ER/Outpatient	Lou	ner	th (Check only one) ursing Home 5 Residence 6 Other (Specify)				
l Records,	n: The law ficate has l rr, page 2 s		25. Was case referre	d to modical	au pp 1 □ Ye						psy ormed? 2 X No	prior to completion of cause of		
1 \subseteq Yes										es 2 🕅 No 3 🗆 Probably 4 🗀 Unknown				
P.O. E	requires that the de been signed by the should be detached	y Phy:	9 Unknown Part II. Other signifi	cant conditions of	ontributing to death b	ut not resu	ulting in the un	derlying cause g	iven in Part I.				ne cause of death?	
Box 68760	To the Hospital or Attending Physician: The law requires that the deam certificate by within 24 hours after death. within 24 hours after death. completed filled in by the funeral director, page 2 should be detached for use as the b	Completed by Physician/Medic	IF FEMALE: 23b. Was decedent in the past 12 n 1 □ Yes 2 □	nonths?	23c. If yes, outcome 1 ☐ Live Birth 4 ☐ Pregnant a 9 ☐ Unknown	2 🗌 Fetal	death 3	Ectopic pregnan	су		- 1	Date of deliver	ery Day Year	
	e be executed ysician and e burial-transit	lical Examiner	Cause (Disease or i that initiated events resulting in death) L	injury	C. Due to (or as a	a conseque	ence of):							
	Examiner	iner	Sequentially list cor if any leading to im cause. Enter Under	ving	b. Due to (or as a		r-1976						Zhrs 4mm	
P	nysician/ Medical		shock, or hear Immediate Cause (F disease or condition resulting in death)	t failure. List only c Final	one oause on each line	ulma	on fai			u premah			Interval Between Onset and Death	
B	permit Depar Impor any fr)	equel	plications that caused	the death	Ruc	ck Towso	n Funer	al Home,	Inc.		n, MD 21204 Approximate	
Baltimore,	treet trant trant jury			5 ☐ Other (Speci	Removal from State fy)		ltop Se	ervice C Name and Addre	Corp. 4/	6/2011	Towson	MD 1050 V	York Road	
re, N	1 and 2 of Health item 27 other t	1	20a. Method of Disp	osition	/ mother	20b. Pla	ace of Disposi			Date Cock	20c. Locatio			
Máryland	should n and Me 7 is mark raumatik		19a. Informant's Na	me/Relationship (7					and Number or	Rural Route Numbe	er, City or Town			
and	oe filed vantal Hyg ked othe c event,	To Be	17. Father's Name (F				<u>-</u>			Name (First, Middle, e Willian		me)		
2121	within 72 giene. er than " the Mer		Elementary/Seco		College (1-4 or 5	+)		NOT use retired;		, on mig	N/A			
21215-0036	ge 1 and 2 should be filed within 12 hours after death with the Maryland it of Health and Mental Hygiene. It fell frem 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examiner must be notified at	Completed by	3 Widowed 4	Divorced 15. Decedent's E		Ţ	16a. Decede	Yes 2X No	pation	vorkina	Speci			
	or items		11. Marital Status 1 💢 Never Marrie	ed 2 🗌 Married	12. Was Decedent E Armed Forces? 1 \(\sum \) Yes 2 \(\sum \)	ver in U.S. No	lf `	Yes, specify Cub	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)	B	ace - Americ lack, White,		
:	with the	Funeral D	3 Beehive		Apt. D			10f. Zip Code 21030			10g. Citizen o	of What Cour	itry?	
:	Marylar 28a-f sh	Director	MD	Baltimo	re		eysvill	le					1 ☐ Yes 2 🎇 No	
, , , , , , , , , , , , , , , , , , ,		r	Usual Residence of I	Decedent 10b. County		10c. City,	, Town or Loca	ition	2 4	Apr. 3,	2011	1	Maryland Od. Inside City Limits	
	Funeral Director	1 S. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthr, Months Days Hours Min. (Month, Day, Year) Coun										place (State or Foreign		
	Medic Examin		4a. Facility Name (if I	not institution, give		ca1	Cente	4b. City, Town, o	r Location of De	ath	4c. County of Death Baltimore			
	Physicia		1. Decedent's Name	(First, Middle, Las	•					2. Date of De		1 1 ear	3. Time of Death 9:48 a M	
		•	For State Registrar		State of Ma	aryland	-	tment of I ificate of I		d Mental Hy	giene Reg. No. 2 (011	10873	
					01 1 5 1 4		1 / D	4	1 141					

JALIEK.

NOTA COAJOE

(BAB/ BOY)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 16^{Day} March 20T1 05:30 Ам Physician/ Irma P. Ancona Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Ginger Cove Health Center Annapolis 9. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth . Age (In vrs. last birthday **Funeral** 1070871913 Pennsylvania 97 096-40-2369 Director Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State be filed within 72 hours after death with the Maryland notified at Director 1 🗆 Yes 2 🖰 No Annapolis Anne Arundel Marvland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? must be Completed by Funeral United States items 23a 4200 River Crescent Drive 21401 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, er than "natural", or iter the Medical Examiner Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: White 3 X Widowed 4 Divorced Year or Dates 15 Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Is marked other than College (1-4 or 5+) Elementary/Seconday (0-12) Nursing Nurse Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Ella Rebecca Wasson ٥ permit, Page 1 and 2 should be fi Department of Health and Menta Important: If item 27 is marked any injury or other traumatic ev Don Chalmers Peterson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 605 S. Saint Asaph St.,Alexandria, Virginia 22314 Department of Health Important: If item 27 any injury or other to once. Peter Ancona/Son 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State 3-17-2011 Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) Kalas Crematory 21. Signature Juneral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Examine the Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 ☐ Probably 4 ☐ Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? autopsy performe 1 ☐ Yes 2 ☐ No certificate 25. Was case referred to medical 26. Place of Death (Check only one) Be 1 Tyes ဂ္ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural After work? injury 5 Pending n 24 hours after death.

• Funeral Director: After pleted filled in by the fun 2 🗌 No Accident Investigation Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature DO029571 no completed cause of death (Item 23a) (Type, Print) E Defense Hwy, Crofton, MD 21114 State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March 16 ື2011 10:00 PM Jane B. Brumm Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Bowie Prince George's Bowie Health Center 9. Birthplace (State or Foreign Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Months 1 🗆 M 2 🗓 F Days Hours Min. NewYork 098-18-7456 Yrs. 87 Director Usual Residence of Decedent 10a. State Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene. 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director notified 28a-f 1 X Yes 2 □ No Maryland Prince George's Bowie 10e Street and Number o 10f. Zip Code 10g. Citizen of What Country? Department of Health and Mental Hygiene. Important; If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be i 3026 Stonybrook Drive 20715 U.S.A. 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. ð 1 Never Married 2 Married Yes 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2 X No Specify: Specify: White 3 XWidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Housewife Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ Roy Knox Clara Bramer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cify or Town, State, Zip Code) 3026 Stonybrook Drive, Bowie, Maryland 20715 Linda Hutchinson/Daughter 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 XXBurial 2 Cremation 3 Removal from State East Newark Cemetery 03/22/2011 Newark, NY 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Boeheim-Pusateri Funeral Home allerd 77 William Street, Lyons, New York 14489 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Examiner enter Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Exami on rest Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or linjury that initiated events resulting in death) Last and Due to (or as a consequence of) attending physician Physician/Medical P.O. Box 68760 for use as 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death been signed by the a should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24 hours after death.

2 hours after death.

Pruneral Director. After this certificate has been heard filled in by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an 2 No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No မ 1 Inpatient 2 ER/Outpatient 3 IDOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural 5 Pending Accident Investigation 6 Could not be 3 Suicide 4 Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined Medical l 🖵 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 To the I only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

MAR 18201

Mirza Nusairee M.D. 1667 Crofton Center, Suite 1, Crofton, Maryland 21114

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Year Month 10: 15gm Physician/ Medical 4a, Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Adventist Hospital ROLKVIlle montgomely If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Funeral Country Wash., Days Hours 7/27/1949 61 **Director** 578-66-3916 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f shov other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2X No MD Anne Arundel Edgewater 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 456 Maple Leaf Dr. 21037 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married White If Yes, Give Year or Dates. 1 ☐ Yes 2 X No Specify: 1969-71 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Safety & Occupational Hlth. Mgr. Federal Gov't. Be 17. Father's Name (First, Middle, Last) Maryland 18. Mother's Name (First, Middle, Maiden Surname) Thomas Bywaters Mary Ellen Mills permit. Page 1 and 2 st Department of Health an. Important: If item 27 is m. any injury or other 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kelly Salvador / Daughter 10194 Shelldrake Circle, Damascus, MD 20872 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place;
Kalas Crematory 1 Burial 2 XCremation 3 Removal from State 3/19/2011 Edgewater, MD 4 Donation 5 Other (Specify) Fundal Service Lensee 21. Signatur 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between pleura lettusius Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical & heart failure Examiner disease Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury signed by the attending physician and d be detached for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicis completed filled in by the funeral director, page 2 should be detached for use as the bur Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

5 Other (specify) IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Month Year 1 ☐ Yes ∠ ☐ 9 ☐ Unknown Part II. **Other significant conditions** contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Least failure, grantes 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? Yes 2 100 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital 1 ☐ Yes 2 ☐ No Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural work? injury 5 Pending Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29d. Date signed (Month, Day, Year) 10068890 115 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Thady Gure Adventist 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar

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MAPCH

WATERS

11-02280 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Kioka Deshaunta Bates State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Registrar Reg. No. 1. Decedent's Name (First, Middle Last) Physician/ 2. Date of Death 3. Time of Death Kicka DeShawnta Eates Medical Examiner Month Day March 24, 2011 0444 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Center Fort Washington Prince George's 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or Director 220 08 1122 Months Davs Hours Min 1 M 2 XF 35 Country) DC 9/28/1975 Usual Residence of Decedent 10a State 10c. City, Town or Location 10d. Inside City Limits MD Charles Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Bryans Road Director Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country 5513 Auburn Court 20616 USA 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 1 Never Married Armed Forces? 2 X Married If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 Yes narked other than "natural", event, the Medical Examiner 3 Widowed 4 Divorced If Yes, Give Yeer 1 Yes 2 No specify: þ Specify:Black 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Itimore, MD 21215-0036 12th Payroll Specialist Steptoe&Johnson 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) is marked Be Larry Butler Gail Young 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald Bates, Jr./ If item 27 5513 Auburn Ct.Bryans Road,MD 20616 Husband 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State crematory or other place) Donation 5 Other Specify: Resurrection Cem. 3/30/201 Clinton, MD Signature of Funeral Service Licensee 22. Name and Address of Facility Briscoe-Tonic Funeral mlerei 2294 Old Washington Rd. Waldorf, MD 20601 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart **Physician** Approximate Interval \/Medical aPulmonary Thromboembolism due to deep vein Thrombosis of left leg Between Onset and ≟xaminer Immediate Cause (Final disease Death or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions. Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Records, P.O. Box 68760, The law requires that the death certificate be executed and Physician/Medical the attending physician and for use as the burial -X UNPENDED AMENDED 23a, 27, per me, g916 6-29-11 sm IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 23d. Date of deliven 1 Live birth past 12 months? 2 Fetal death 3 Ectopic pregnancy Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 V Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available has autopsy prior to completion of cause of performed? certificate death? ✓ Yes 2 No 1 Yes 2 No Division of Vital 25. Was case referred to medical Be 26.Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ✔ ER/Outpatient 3 this ٩ Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 2 No Manner of Death 28a. Date of Injury (Month, Day Year 28b. Time of Injury Certification 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural Director: d in by the f 1 Yes 2 No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be 28f. Location (Street and Number or Rural Route Number, City within 24 hours at To the Funeral D or Town, State) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Medical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) **OCMF** O.C.M.E March 25, 2011

State

Registrar

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

Registrar's Signatu

30. Name and address of person who completed cause of death (Item 23a)

Theodore M. King, Jr., MD.

31. Date filed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 18, 2011 0550 hrs Medical Examiner Christopher K. Bell 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Worcester 703 St. Louis Avenue Unit C Ocean City 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or **Funeral** 19 Scount Wash. DC Months Davs Hours 15, Director Nov. 216-96-9164 47 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a, State 10b. County 1 Yes 2 X No or items 23a or 28a-f show must be notified at once. more, MD 21215-0036
Pages I and 2 should be filed within 72 hours after death with the Maryland rent of Health and Mental Hygiene. MD Ocean City Director Worcester 10g. Citizen of What Country 10e Street end Number 10f. Zip Code 703 St. Louis Ave. 21842 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S White, etc. Armed Forces? 1 Never Married 2 Married 1 Yes 4 Divorced If Yes, Give Yeer white 1 Yes 2X No specify: 2 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Dccupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) the Medical Comple Security Guard Hotels 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Patricia Pease Donald Bell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) tant: If item 27 is n or other traumatic Newport Dr. Ocean Pines, MD 21811 Patricia Pease-Mother 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Removal from State Department o 3-21-11 Millsboro, DE First State Crem. 4 Donation 5 Other Specify 22. Name and Address of Facility Burbage Funeral Home ure of Funeral .08 William Street Berlin, MD art I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and Medical Death a Myocardial Infarction Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or es a consequence of): b. Atherosclerotic Cardiovascular Disease Sequentially list conditions, are to for as a consequence of if any leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Hospital or Atteoding Physician: The law requires that the death certificate be executed pur Physician/Medical UNPENDED AMENDED attending physician or use as the burial Box 68760, 23d. Date of deliven 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Year Day Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the signed by 1 23e. Did tobacco use contribute to the cause of death? o Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ゑ 1 Yes 2 No 3 Probably 4 Unknown Records, P. Completed 24b. Were autopsy findings available has been 24a. Was an prior to completion of cause of autopsy performed death? ✓ Yes 2 No certificate 1 Yes 25. Was case referred to medical 26.Place of Death (Check only one) of Vital Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other4 Nursing Home 5 Residence 6 ✔ Other: Scene this 1 🗸 Yes No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28b. Time of Injury 28d. Describe how injury occurred After 27 Manner of Death 1 V Natural 1 Yes 2 No Director: d in by the f Pending Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined 24 hours a Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) To the 2 within 2 To the 3 complet and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) March 19, 2011 O.C.M.E. 30. Name end/address of person who completed cause of death (Item 23a) Melissa Brassell, MD **Assistant Medical Examiner** 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day Year) 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

OCME

ORIGINAL

Please Type or Print in Black Indelible Ink. Frayre All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Manth 30-2011 WALLACE WOOD CAMPBELL, SR. 1400 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** ST. MARY'S CALLAWAY ST.MARY'S HOSPICE HOUSE If Under 1 Year If Under 24 Hrs. . Social Security Numbe 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 🔀 M 2 🗆 F Months Days Hours Min. 4-29-1927 VA. 228-22-9300 83 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director ST.MARY'S CHARLOTTE HALL MD. 1 Yes 2X No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 38259 WALTER COURT 20622 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces?

1 Y Yes 2 No ARMY
If Yes, Give Black, White, etc. 1 Never Married 2 X Married þ Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Widowed 4 Divorced WWII Completed Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) SELF EMPLOYED LOCKSMITH 8th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) MAMIE E. SANFORD JOHN R. CAMPBELL 19a. Informant's Name/Relationship (Type, Print) bb. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)
38259 WALTER CT. CHARLOTTE HALL, MD. 20622 BARBARA CAMPBELL-SPOUSE permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 ☐ Burial 2X Cremation 3 ☐ Removal from State | Cemetery, crematory or other place;
4 ☐ Denation 5 ☐ Other (Specify) | METROPOLITAN | CREMATORY 3-31-11 ALEX., VA. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 21. Signature of Juneral Service Licenses M00479 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition Onset and Death Physician/ Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 - Fetal death in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a Id be detached f 9 Unknown g 🗌 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, 2 No 3 Probably 4 Unknown 1 Yes Completed been si 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has all director, page 2 performe 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 2. No 1 🗌 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 6 Other (Specify After thi 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending n 24 hours after death.

e Funeral Director: Aft
bleted filled in by the fur 1 Yes 2 No Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier within 24 hor To the Fune completed fi 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year, H005575 201 Jennifer Schmidt, 20900 Merchants Lane, Suite 205, Leonardtown MD 30. Name and address 20650 31. Date filed (Mg PRy, Yea 2. Registrar's Signa State rocur Registrar

DHMH 17 Rev 7/2009

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Edward	Wi

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

dward William De	1	- For State	ate of Maryla		artment o <i>rtificate o</i> i		Mental Hy		2 0 teg. No.	remedian	10880	
	Physician/ 1. Decedent's Name (First, Middle,Last)								ath Day Year		. Time of Death	
Medical Examine		Edward Willi 4a. Facility Name (if not institution	· ·			4b. City, Town, or Lo	ocation of Death	Month March 7,			1155 hrs	
		7700 Sharewood Driv	· =	,	į	Jessup			Howard			
Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	If Under 1 Year Months Days	If Under 24Hrs. Hours Min.	8. Date of Bi	rth(MM/DD/YYYY)	Foreign		
Director		126-36-9203	1X M 2 F	65	Yrs		,,,,,,	08/10/1	1945	Count	try) New York	
ABY		Usual Residence of Decedent 10a. State 10b. County		10c. City	, Town or Locat	ion				1	0d. Inside City Limits	
and [show	5	Maryland Howard	L	Je	ssup						1 Yes 2 No	
Maryl	Lect	10e. Street and Number		-		10f. Zip Code			10g. Citizen of Wh	at Country	y?	
eath with the Maryland items 23a or 28a-f sho ust be notified at once	runeral Director	7700 Sharewood Dr 11. Marital Status		edent Ever in U	IS 13. Wa	20794 as Decedent of Hispa	anic Origin? (Sp	ecify Yes or No	USA No- 14. Race - American Indian, Black,			
leath w	nue	1 Never Married 2 N				es, specify Cuban,			White		,	
after c	5		vorced If Yes, Give Yes	′ 65 - 67	1	Yes 2 X No			Specify:	Whi		
2 hours		 Decedent's Education (Spe Elementery/Secondary (0-12) 				nt's Usual Occupation ost of working life. [16b. Kind of Bus		ustry	
036 ithin 7.	Completed	12			Safety	Technician	ı		Environme	ental	Services	
	3	17. Father's Name (First, Middle Edward Decker	, Last)					,	Maiden Surname)			
2121 uld be fil marked e event,	9 0	19a. Informant's Name/Relations	ship (Type, Print.)		19b. Mailin	g Address (Street	Lucille S		7	n, State, Z	Zip Code)	
MD d 2 sho lth and n 27 is numation	L	Gretchen Decker	- Wife			harewood Dr						
Baltimore, Mi permit Pages I and 2 is Department of Health a Important: Iftem 27, injury or other fraum		20a. Method of Disposition 1 Burial 2 X Cremation	n 3 Removal fr	a I	crematory or of	sition (Name of ceme her place) ashington C	·	Date	20c. Location -	•	·	
Baltimore, ocmit. Pages 1 ar Jepartment of Hee Important: If ite	-	4 Donation 5 Other S		Da		_	1		Laurel, N	aryıa	nd	
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Division of Vital Records, P.O. Box 68760, Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. Fuoral Director: After this certificate has been signed by the attending physician and tely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical Examine	UNPENDED	dAMENDED							\dashv		
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ivision or Atten after death Director:	<u> </u>	2 Accident Inve	estigation 28e Plac	e of Injury - At	home, farm, stre	et, factory, office bu		28f. Location	(Street and Numb	er or Rura	al Route Number, City	
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0111211	+	30. Name and address of person	•	•								
(11111)			Assistant Medica	al Examiner gistrar's Signa		altimore Street	, Baltimore, I	MD 21223				
Sta Registra	te ar	31. Date filed (Month, Pay, Year,	8 2011	gistrar's Signa	1. So	ake						

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State Registrar

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Eric B. Lieberman, M.D. 1400 Forest Glen Rd. #200, Silver Spring, MD 20910

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

31. Date filed (Month, Day, Year) MAR 1 8 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 4/35 A M SYLVESTER Mara DOUGLAS, SR. 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner DOCTORS COMMUNITY HOSPITAL LANHAM PRINCE GEORGE Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Age (In yrs. last birthday, **Funeral** Months Days Hours Min. 5-17-1929 **Director** 248-38-1074 81 Usual Residence of Decedent f show 10a. State 10b. County items 23a or 28a-f sho her must be notified at within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director 1 😾 Yes 2 🗌 No MD PRINCE GEORGE HYATTSVILLE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 20785 U.S.A. 7721 GREENLEAF ROAD 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc 0 þ 1 Never Married 2XXMarried 1 √ Yes 2 No If Xes, Give Baltimore, Maryland 21215-0036 1 Yes 2 No Specify Specify: BLACK Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) ed other than " Elementary/Seconday (0-12) College (1-4 or 5+) should be filed within and Mental Hygiene. CONSTRUCTION SUPERVISOR MD NATIONALPLANNING COM 8TH GRADE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ be permit. Page 1 and 2 should be f Department of Health and Menta Important: If item 27 is marked any injury or other traumatic er BUELAH McCULLOUGH LOUIS DOUGLAS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailling Address (Street and Number or Rural Route Number, City or Town, State, Zio Code) 7721 GREENLEAF ROAD HYATTSVILLE, MD 20785 IDA M. DOUGLAS-WIFE 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MD NAT 3-26-2011 LAUREL, MD . Signature of Funeral Service Licensee 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 524 - 8TH ST., N. E. WASH.. DC 20002-5236 23a. Part 1. Enter the disease, or complications that caused the death. On not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ RESPIRATORY FAILURE disease or condition Medical resulting in death) Due to (or as a consequence of) **Examiner** PNEUMONIA Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to for as a nunseouence of or Attending Physician: The law requires that the death certificate be executed FUNGAL SEPSIS attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of) Completed by Physician/Medical METASTATIC ESOPHAGEAL CANCER Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? 1 Yes 2 9 Unknown 2 No the 9 Unknown been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? should be END STAGE RENAL DISEASE 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available 24a. Was an SEPTIC SHOCK cate has by page 2 s prior to completion of cause of death? performed? Yes 2X No this certificate PERIPHERAL VASCULAR DISEASE 2 No 1 Yes Be (25. Was case referred to medical 26. Place of Death (Check only one, examiner? Hospital: Certificate: To 1 ☐ Yes 2 🗓 No Other: 1 Npatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28c. Injury at work? 28b. Time of 28d. Describe how injury occurred eral Director: After filled in by the funer 1 X Natural 2 Accider 5 Pending 1 🗌 Yes 2 🗆 No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital within 24 hours a To the Funeral D Hospital Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifle 29c. License number 29d. Date signed (Month, Day, Year) D52500

State Registrar FOZIA ABDULWAMABE, M.D. 8118 GOOD LUCK ROAD LANHAM, MD 20706

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

31. Date filed (Month, Day, Year,

MAR 2 3 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ison 8:40 P March Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Wicomico Salisbury Wicomico Nursing Home Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours Min 1 M 2 D F Director or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Funeral Director items 23a or 28a-f s her must be notified 1 PYes 2 No 10e. Street and Number 10g. Citizen of What Country? 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☑ Yes 2 ☐ No 1954
If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ٥, Completed by 1 Never Married 2 Married Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🗹 No Specify: Black "natural" 3 Widowed 4 Divorced 1956 Year or Dates the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မှ 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, Important: If item 2 any injury or other once. 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, Date 1 M Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 4Urlock 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Home, P. A 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if all y, cool get on the cause. Enter Underlying Cause (Disease or linjury Examiner Duri to for as a nonsequence of the attending physician and hed for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Day Year Yes To the Funeral Director; After this certificate has been signed by the a completed filled in by the funeral director, page 2 should be detached 1 ☐ Yes 2 ☐ 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 No 2 1 1 Tes the Hospital or Attending Physician: Be (25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 2 100 Other: မ 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Unursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred (Month, Day, Year) 1 Natural injury 5 Pendina 2 Accident within 24 hours after death. To the Funeral Director; At Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Gertifying Number Practionary To the basis of my kinemacy, death continued at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 24 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 910 Easternshore Dr Salisbury MD 21804 Mahesha Thimmarayappa M.D. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. TorAMEND#14 per FH State of Maryla State 3/21/2011 AACO HEALTH DEPT OME Registrar State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death ^{Day} 2011 Month Physician/ March 1:38 Arthur Donald Enty Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 XM 2 🗆 F Months Days Hours Min. e 1 Director 62-26-2147 79 June 1931 Pennsylvania Usual Residence of Decedent filed within 72 hous ware.
Ital Hygiene.
ed other than "natural", or items 23a or 28a-f show
es other than "natural" ar items 23a or 28a-f show
es out, the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 X Yes 2 □ No Maryland Prince George's Bowie 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12100 Maddox Lane 20715 USA 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 Ayes 2 1955
If Yes, Give Year or Dates. 1977 Black, White, et lack/White 1 Never Married 2 Married <u></u> Maryland 21215-0036 1 ☐ Yes 2 Ϊ No Specify. Specify: White 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) United States Elementary/Seconday (0-12) College (1-4 or 5+) 5+ Personnel Management Air Force 17. Father's Name (First, Middle, Last) should be file and Mental H is marked oth 18. Mother's Name (First, Middle, Maiden Surname, 2 Arthur Enty Adela Paul 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is Susan A. Enty/ Daughter 12100 Maddox Lane Bowie, MD 20715 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemeter) Trematory or other place)
National Cemetery 20c. Location - City or Town, State 1 🗴 Burial 2 🗆 Cremation 3 🗆 Removal from State any injury or Arlington, VA 4 ☐ Donation 5 ☐ Other (Specify) unk 21. Signature of Funeral Service License 22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road Bowie, MD 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ a. Die to (or as a consequence of): disease or conditi-resulting in death) Medical Examine Sequentially list conditions, if any, leading to immediate Examine Due to (or as a consequence of): nding physician and use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No Day Year Pregnant at time of death ate has been signed by the a page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Hospital or Attending Physician: The law requires Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Mabdomyalysis 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 🗆 No Yes 2 1 Yes 25. Was case referred to medical a B examiner? 26. Place of Death (Check only one) Hospital Other: မူ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 V Natural 5 Pending injury work? 1 ☐ Yes 2 ☐ No s after death.
I Director: Aff Accident Investigation 2 Accider
3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Exam (Check mer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only one Certifying Murse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and tiple of certifi 29c. License number **D58510**

TILO State Registrar

Box 68760

P.0.

Records,

Division of Vital

DHMH 17 Rev 7/2009

30. Name and address

31. Date filed (Month

of person who completed cause of death (Item 23)

MAR 18201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2 Date of Death March Physician/ 2011 2:57 Рм Donald L. Eister Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Edgewater 1746 Shore Drive If Under 1 Year If Under 24 Hrs 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth 7. Age (In yrs. last birthday) Funeral 1 🖫 M 2 🗆 F Days Hours 11/15/1946 Mary Tand **Director** 225-66-3960 64 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 🗆 Yes 2 🔀 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? United States 1746 Shore Drive 21037 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White If Yes, Give Year or Dates. 1965–68 1 ☐ Yes 2 X No Specify: Completed 3 Widowed 4 X Divorced Page 1 and 2 should be filed within remover then of Health and Mental Hygiene. Trant: If item 27 is marked other than "natur: rant: free Medical J 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Welder Construction 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Dora Vandella Steffen Charles Leon Eister 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Stephen L. Eister/Son 1746 Shore Drive, Edgewater, Maryland 21037 permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State 1 🕭 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) akemont Memorial Gardens 03/22/2011 Davidsonville, Maryland . Signature Al Any Arvice Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final MarcTior Ph sician/ Medical resulting in death) Due t or as a consequence of Examiner hemic Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Cause (Disease or iinjury that initiated events resulting in death) Last To the Hospital or Atternding Physician: The law requires that the death certificate be executed use as the burial-trans and attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Year Month Day Pregnant at time of death be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ emia 5,0 Yes 2 No 3 Probably 4 Unknown Completed been s 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Jas autopsy performed Yes 2 page After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital |2 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 X Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 5 Pending fter death. 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by 4 Homicide determined City or Town, State) within 24 hours
To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 🗆 Certifying Nurse Practio To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier MARCH Name and address of person who completed cause of death (Item 23a)

Registrar DHMH 17 Rev 7/2009 strar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Month 3 20^{Day} Physician/ 2011 2:30 AM Edward A. Engelmann Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Berlin Worcester 12544 River Run Lane If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Days Hours 9/21/1927 1 🔀 M 2 🗆 F 83 Director 217-20-7315 MD Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits be filed within 72 hours after death with the Maryland Director than "natural", or items 23a or 28a-fs he Medical Examiner must be notified 1 Yes 2 No MD Berlin Worcester 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 12544 River Run Lane 21811 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 XYes 2 No 1 Never Married 2 K Married Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify. Specify. 3 Widowed 4 Divorced white Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) and Mental Hygiene. 4 Chemical Engineer Pharmaceutical Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Page 1 and 2 should be file ment of Health and Mental | tant: If item 27 is marked o ည Carl Engelmann Katie Brodt 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr once. Betty Jane Englemann wifle 12544 River Run Lane, Berlin, MD 21811 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 1 Burial 2 XCremation 3 Removal from State First State Crem. 3/22/2011 Millsboro, DE 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Licenses 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Death enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Due to (or as Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Examine Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit Cause (Disease or linjury that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Dav Year Pregnant at time of death 2 No 2 should be detached 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Trobably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy page performed 1 🗌 Yes 2 🖼 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) Hospital 2 No 1 🔲 Yes ျ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Amesidence 6 Other (Specify) this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: After 1 Natural injury 5 Pending 1 ☐ Yes 2 ☐ No 24 hours after death. Funeral Director: A 2 Accident
3 Suicide
4 Homicide Investigation the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, completed filled in by determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 ☐ Medical Examiner
3 ☐ Certifying Nurse P Medical Examiner: Open basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check actioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2. 29b. Signature and title of certifier 29d. Date signed (Modth, Day, Year)

BA12+1

State Registrar 30. Name and address of person

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) State
Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ 12:01 PM enwi Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Plata If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign 1 ★ M 2 □ F Months Days JULY 13, 1956 217-66-2489 54 WASHINGTON, D.C. **Director** Usual Residence of Decedent or 28a-f shov 10b. County or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director MARYLAND CHARLES BRYANS ROAD 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 3433 PEERLESS PLACE 20616 UNITED STATES Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces?

1 Yes 2 No
If Yes, Give
Year or Dates. Black, White, etc ģ 1 Never Married 2X Married 1 ☐ Yes 2X No Specify: BLACK Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12)

10TH GRADE College (1-4 or 5+) HEAVY EQUIPMENT OPERATOR CONSTRUCTION any injury or other traumatic event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ROY LEE FOX LUCILLE LILLIAN FENWICK HICKS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is BRENDA C. FENWICK / WIFE 3433 PEERLESS PLACE, BRYANS ROAD, MARYLAND 20616 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State altimo 1X Burial 2 Cremation 3 Removal from State ST. JOSEPH'S CHURCH CEM. MARCH 28, 2011 POMFRET, MARYLAND 4 Donation 5 Other (Specify) ZIDIA C. THORNTON JOHNSON MO0583 THORNTON FUNERAL HOME, P.A 3439 LIVINGSTON ROAD. INDIAN HEAD. MARYLAND 20640 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Ph_sician/ Pulmonary disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examine Due to (or as a consequence of) ending physician and use as the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 Probably 4 Unknown Completed Were autopsy findings available prior to completion of cause of 24a. Was an autopsy death? 1 ☐ Yes 2 ☐ No 25. Was case referred to medical Be 26. Place of Death (Check only one) 2 1 🗌 Yes 2 No Other: 1 Dopatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) After this funeral i 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury 1 🗌 Yes 2 No Investigation
Could not be 2 Accident filled in by the Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number ☐ Homicide City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed (Check only one 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signatur and title of certific 29d. Date signed (Month, Day, Year, 22 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 102 132 ames Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month ()3 2011 8:45 Jacqueline Myers Flanders Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death **Examiner** 4b. City. Town, or Location of Death Chesapeake Beach 6423 4th Street Calvert Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Days 1 🗆 M 2 🕱 F Months Hours Min 08/07/193 Director 219-28-7966 78 MD Usual Residence of Decedent or than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City Town or Location 10d. Inside City Limits Director 1 ☐ Yes 2 🗓 No MD Prince Georges New Carrollton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8333 Carrollton Parkway 20784 United States 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☒ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working should be filed within 72 and Mental Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Administrative Assistant Computers Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Department of Health and Menta Important: If item 27 is marked, any injury or other training. မ John Henry Myers Lillian McCormick 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Laura Flanders-Roush/Daughter 16420 Bonney Road, Watsonville, CA 95076 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2 🛛 Cremation 3 ☐ Removal from State 4 Donation 5 Dother (Specify) Lee Crematory 03/24/2011 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Lee Funeral Home Calvert, Bary J. Goff 8125 Southern Maryland Blvd., Owings, MD 20736 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) olon cance Medical Due to (or as a consequence of) Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Day Year 1 ☐ Yes ∠∠ 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has irector, page 2 performed Yes 2 N 2 🗆 No 1 🗌 Yes 26. Place of Death (Check only one)

Other:

A Daughter

Nursing Home 5 Residence 25. Was case referred to medical Be examiner? Hospital 2 No 1 Tes မြ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 XNatural 5 Pending s after death.

al Director; Af 1 Yes 2 No ☐ Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by determined 24 hours a Medical Hospital 29a. Certifier Scertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 2 Medical Examiner: On the basis of examination and/or investigation, in tily opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the P within 2 29b. Signature and title of certifie 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20678 TRW

State Registrar

Maryland 21215-0036

Baltimore,

Box 68760

P.O.

Records,

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02403 State of Maryland / Department of Health and Mental Hygiene Clementyne Fishman 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 28, 2011 1500 hrs Mવ્dical Examiner Clementyne Antoinette Fishman 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Montgomery Shady Grove Adventist Hospital Rockville 9. Birthplace (State or Foreign Maryland If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days Hours 213-13-3681 Director 11/18/1986 1 M 2 XX F 24 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 1 X Yes 2 No Maryland Frederick Mount Airy ges I and 2 should be filed within 72 hours after death with the Maryland of Heath and Mental Hygiene.

Hitem 27 is marked nther than "natural", or items 23a or 28a-f shu Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 102 Grimes Court 21771 United States 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc Armed Forces? 1 X Never Married 2 Married 1 Yes 2 X No White Specify: If Yes, Give Year 1 Yes 2 X No specify: inther than "natural", 2 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) Elementary/Secondary (0-12) Early Education 2 Teacher 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tina M. Jones Be Robert Fishman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a, Informant's Name/Relationship (Type, Print) 2294 Belgian Ln. #2, Clearwater, FL 33763 Tina Fishman / Mother 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, April 1, 20a. Method of Disposition crematory or other place) Resthaven 1 X Burial 2 Cremation 3 Removal from State permit Pages
Department of
Important: I 2011 Frederick, Maryland Memorial Gardens 4 Donation 5 Other Specify 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Resthaven Funeral Services, Skkot Cody P.A. 9501 Catoctin Mountain Hwy. Frederick, Approximate Interval reations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear 23a. Part I. Enter the disease, or cor Physician Between Onset and failure. List only one cause **/Medical** Death Could not be determined Immediate Cause (Final dise or condition resulting in d h) Åxaminer Due to (or as a consequence of) Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): transi and cian/Medical 23a,27,28a-f per me 28c per me g915 5-11 g914 4-22-11 vt X AMENDED X UNPENDED ned by the attending physician detached for use as the burial Division of Vital Records, P.O. Box 68760, 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 3b. Was decedent pregnant in the Day Year 2 Fetal death 3 Ectopic pregnancy 1 Live birth past 12 months? Pregnant at time of death 5 Other (Specify) Physic Yes 2 No 9 🗸 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≦ 1 Yes 2 No 3 Probably 4 V Unknown Completed Arter this certificate has been the funeral director, page 2 should to 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed Yes 2 ✔ No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifi 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other Hospital: 1 Inpatient 2 🗹 ER/Outpatient 3 🗌 DOA 2 No 1 Yes 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred 27. Manner of Death unk Natural 1 Yes 2 5 Pending the fd 3-28-11 Ed 2:10pm unknown 28f. Location (Street and Number or Rural Route Number, City or Town, State) 2200 Baltimore Rd. Rockville, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. filled in by 6 X Could not be Suicide determined (Specify) found at place of employment Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated

State Registrar

29b. Signature and title of certifier

Zabiullah Ali, M.D.

31. Date filed (Month, Day Year) 201

30. Name and address of person who completed cause of death (Item 23a)

Assistant Medical Examiner

32. Registrar's Signature

MYCHEAN.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License numbe

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

March 29, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month **Physician** 30 A M Flook 03 28 2011 Ann Judy /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Washington Cascade 14521 Water Company Rd. Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) **Funeral** Min. Months Days Hours 1 □ M 2 K F 69 218-38-1734 21 1941 Waynesboro, PA Director 11 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location th and Mental Hygiene. 7 Is marked other than "natural", or thems 23a or 28a-f show traumatic event, the "scrient Examiner must be notified at 10a. State 10h County 1 □Yes 2 No Director MD Washington Cascade 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code death with US 21719 14521 Water Company Rd. Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black White etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married Specify: white Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Excavating business accounting/bookkeeping 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marie Anna Smith Glenn E. Gaver ည 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cascade, MD 21719 Health sem 27 l 14521 Water Company Rd. Box 24 Gene Richard Flook other t 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) inf P $04/01^{at}$, 2011 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. Cumberland Valley Crematorium Waynesboro, PA 17268 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licenses Grove-Bowersox Funeral Home, Inc 50 S. Broad St. Waynesboro, PA 17268 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) PLEURAL EFFERSON Examiner Cel 12 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, IF FFMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) cate has been signed by the a page 2 should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 1 Yes 2 No certificate I funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To After this 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural 2 ☐ Accident To the Hospitar ... within 24 hours after death.
To the Funeral Director: After maletely filled in by the fur 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only

State Registrar

DHMH 17 Rev 1/2001

29b. Signature and title of contifier

31. Date filed (Month, Day, Year)

Ernest K. Amegashie

APR 0 5 201

30. Name and address of person who completed cause of death (Item 29a) (Type, Print)

32. Registrar's Signature

29c. License number

339 East Antietam Street Hagerstown MD

29d. Date signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death GRANDFSKY Physician/ 1242 M 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Center Annapolis Anne Arundel . Social Security Number If Under 1 Year I If Under 24 Hrs. Funeral 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 F Hours Min. April Day Mary Land 215-16-6847 87 **Director** Usual Residence of Decedent 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1604 Bentley Road 21037 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 X Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: White 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) John Stock Anna Karasave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eileen F. Lyle / Daughter 1609 Midland Road, Edgewater, Maryland 21037 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place)
Kalas Crematory 1 Burial 2 X Cremation 3 Removal from State 3-18-2011 Edgewater, Maryland 4 Donation 5 Other (Specify) 21. Signature of Puneral 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd., Edgewater, MD 21037 23a. P irt 1. Enter ne disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, s lock, or leart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Examin To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 ☐ Yes 2 ☐ No
9 ☐ Unknown Pregnant at time of death Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 D No 1 T Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) completed filled in by the funeral director, Hospital 2/ No Other: ျပ 1 Yes 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending injury 1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Signature and title of 21438 ame and address of person who completed cause of death (Item 23a) (Type, Print) Registrar's Signature State Registrar

Records, P.O. Box 68760

Division of Vital

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death MMarch 22 Physician/ <u> Alice Louise Hessler</u> Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death 11221 Greenmount Ave. Washington Hagerstown Social Security Number If Under 1 Year I If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea June 7, 192 7. Age (In vrs. last birthday) **Funeral** 1 🗆 M 2 🕇 F 213-18-9911 Director Yrs 89 June /, Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Madical Exercises 10a, State 10b. County 10c. City, Town or Location Director Washington Hagerstown 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 11221 Greenmount Ave. 21740 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Race - American Indian 1 ☐ Never Married 2 🗷 Married Completed by 1 Yes Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3
Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) College (1-4 or 5+) +2 Elementary/Seconday (0-12) Homemaker Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ൧ Andrew S. Baker Goldie Imogene Snowberger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Eric P. Henson / Son 13830 Big Pool Rd, Clear Spring, MD 21722 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Norland Cemetery 03/26/2011 Chambersburg, PA 21. Signature of Euneral Service Licensee 22. Name and Address of Facility Gerald N. Minnich Funeral Home 305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final CONGESTIL Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): the burial-transit Cause (Disease or iinjury that initiated events and resulting in death) Last Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) 2 No 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Cho HYPBRTEN PIO 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? performed Division of Vital 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital Other: 4 Nursing Home 5 Residence 6 Other (Specify, 2 1 No 1 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manne of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Hospital or Attending P 24 hours after death. 1 Natural 5 Pending within 24 hours after death.

To the Funeral Director: Af
completed filled in by the fu 1 Yes 2 No ☐ Accident Investigation Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 20022313 6212 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hagerstown Oak 31. Date filed (Month, Day, Year)

2011

Black, White, etc.

Month

1 Yes

Day

2 🗌 No

Year

White

7:58 PM

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

1 X Yes 2 □ No

Waynesboro, PA

Registrar DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 03 Physician/ JANET HUGHART Year PM 6:21 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death BALTIMORE UNIVERSITY OF MARYLAND MEDICAL 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral Hours Min 1473671942 Marvrand Director 219-40-6064 68 Usual Residence of Decedent ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Crownsville 1 🗆 Yes 2 ื No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 533 Ridgely Road 21032 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, 11. Marital Status Armed Forces? Black, White, etc. þ 1 Never Married 2 Married White If Yes, Give Year or Dates 1 ☐ Yes 2 X No Specify: 3 Widowed 4 X Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) 12 Elementary/Seconday (0-12) Realtor Real Estate Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Dale Moses Mildred Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Brent Hughart/Ex-Husband</u> Admiral Dr. #401, Annapolis, MD 21401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State Baldwin UMC Cemetery 3/21/2011 Millersville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility John M. Taylor Funeral Home Myelin 147 Duke of Gloucester St, Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death 7 DAYS Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or imjury Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown 5 Other (specify) Month Day Year signed by the a Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?
☐ Yes 2 💢 No 2 X No certificate 25. Was case referred to medical funeral director. Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) မ 1 🗌 Yes 2 No 1 X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA To the Hospital or within 24 hours after death.

To the Funeral Director: After thi 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Certificate: 28b. Time of 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation in my policy death. Medical 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, dueth occurred at the time, date and plane, and due to the course(s) and marker as state. 29d. Date signed (Month, Day, Year) * Katherine P25541 March 15,2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Katherine Schrenk

Registrar DHMH 17 Rev 7/2009

Baltimore, Maryland 21215-0036

P.O. Box 68760

Records,

Division of Vital

Baltimore, MD

S. Greene Street

22

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month М Houdersheldt Physician/ Mae Maphis Martha Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Allegany **Examiner** Cumberland WMHS-RMC g. Birthplace (State or Foreign If Under 1 Year If Under 24 Hrs. 8. Date of Birth 7. Age (In yrs. last birthday) May 20, 1925 Country) WV 5. Social Security Number Months Days Hours **Funeral** 1 □ M 2 □**y**F Yrs. 215-68-5941 85 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location tal Hygiene. of other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at 10b. County 10a. State Director Ridgeley 1 Yes 2 X No Mineral WV 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 26753 Funeral Rt. 2 Box 44 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. filed within 72 hours after death 11. Marital Status Black, White, etc. Armed Forces? 1 ☐ Yes 2 ☐ No Specify 1 Never Married 2 Married ρ Specify: white Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 3 XWidowed 4 ☐ Divorced Completed 16b. Kind of Business Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) own home homemaker 18. Mother's Name (First, Middle, Maiden Surname) Be 17. Father's Name (First, Middle, Last) of Health and Mental H fitem 27 is marked ot rother traumatic even Ethel Maphis 2 Columbus Parsons 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip 37 Potomac Street Cumberland MD 21502 19a. Informant's Name/Relationship (Type, Print)
Sue Ann Goss daughte Important: If item 27 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition WV Burial 2 Cremation 3 Removal from State 3/30/201 Department of Short Gap Abe Cemetery ò 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee 22. Name an Scarpent Prilieral Home, PA once, any 108 Virginia Avenue: Cumberland, MD 21502 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset land Death Immediate Cause (Final disease or condition resulting in death) MOCO HZ Physician/ Due to (or as a consequence of) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Examiner burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be ethin 24 hours after death. Records, P.O. Box 68760 IF FEMALE: 23d. Date of delivery 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death for use 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ Month Day in the past 12 months?
1 Yes 2 No Pregnant at time of death 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 No 3 Probably 4 Unknown ģ Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops\ performed' 2 🗌 No 1 Yes 20 No Yes 26. Place of Death (Check only one) 25. Was case referred to medical **Division of Vital** Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) examiner? Inpatient 2 ER/Outpatient 3 DOA 2 No 1 Tyes မ 28c. Injury at 28d. Describe how injury occurred 28b. Time of 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: injury 5 Pending 1 ☐ Yes 2 ☐ No 1. A Natural 28f. Location (Street and Number or Rural Route Number, City or Town, State) Investigation Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after deat To the Funeral Director: 6 Could not be Suicide 3 ☐ Suicide 4 ☐ Homicide determined Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier only one) 29c. License number 29b. Signature and title of certi D0033280 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CLUMBERLAND, MD 21503 AVENUE SUPIL GUPTA M.D 625 KENT 32. Registrar's Signature 31. Date filed (Month, 5 **State**

DHMH 17 Rev 7/2009

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Registrar

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Baltimore, Maryland 21215-0036 Division of Vital Records, P.O. Box 68760

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Q □ E e o	Ш	305 N. Potomac St., Hagerstown, MD 21740 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate														
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To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu	Medical	(Check 2	☐ Medical I	g Physician: To the bes Examiner: On the basis g Nurse Practioner: To	of examinati	on and/or	investi	igation, in my	opinior	n, death o	occurred at	the time, date a	and p	lace, and du	e to the	cause(s) and manner stated
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Stat	e_	31. Date filed (Mon	A POYOD!	2014 32. geg	istrar's Sign		ر لا	1 1 11	** -	ノバ	ωı,	nwou t) IU	147	. 10	01/10
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1 - For State Registrar		k Indelible Ink. Ensure f epartment of Health and N Certificate of Death	2 0 1 l	10896					
1. Decedent's Name (First, Middle, Last) Physician/ Medical MARIENE	GROSS	KEGLEY	2. Date of Death Month March	24, 2011	3. Time of Death				
Examiner 4a. Facility Name (if not institution, give street	eet and number)	4b. City, Town, or Location of Death	11011011	4c. County of Death	<u> </u>				
2210 Nelson Mil 5. Social Security Number 6. Sex	1 Road 7. Age (In yrs. last birthda	Jarrettsv: av) If Under 1 Year If Under 24 Hrs.	.11e 8. Date of Birth	Harf	ord place (State or Foreign				
	215-40-0592 1 M 2 X F 69 Yrs. Months Days Hours Mi								
To state 10b. County	10c. City, Town or	r Location			10d. Inside City Limits				
MD. Harf	ord	Jarrettsv:		g. Citizen of What Cou	1 ☐ Yes 2 📉 No				
Land Status 11. Marital Status 12. Punetal Marital Status 12. Marital		21084		United S	tates				
© 1 □ Never Married 2 M Married	2. Was Decedent Ever in U.S. Armed Forces 2. 1 ☐ Yes 2 M No If Yes, Give Year or Dates.	 Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto Yes 2 No Specify: 	ecify Yes or No- Rican, etc.)	14. Race - Americ Black, White, Specify:					
3 Widowed 4 Divorced 15. Decedent's Educ (Specify only highest grade (Specify only hi	completed) (G	ecedent's Usual Occupation live kind of work done during most of worki a. DO NOT use retired)	ng 16	6b. Kind of Business In	dustry				
State in the Market in the Mar	College (1-4 or 5+)	Owner		Beautici	an				
17. Father's Name (First, Middle, Last)		18. Mother's Name	e (First, Middle, Mai	iden Surname)					
Aaryland Aar	enneth Gro				lmony				
19a. Informant's Name/Relationship (Type, George L. Kegle)	, , , , , , , , ,	lailing Address (Street and Number or Rura O Nelson Mill Ro		ty or Town, State, Zip o					
20a. Method of Disposition 1 A Burial 2 Cremation 3 Re 4 Donation 5 Other (Specify) 21. Signature of Funcial Service Lights 22. Signature of Funcial Service Lights 23. Signature of Funcial Service Lights 24. Signature of Funcial Service Lights 25. Signature of Funcial Service Lights 26. Signature of Funcial Service Lights 26. Signature of Funcial Service Lights 27. Signature of Funcial Service Lights 28. Signature of Funcial Service Lights 29. Signature of Funcial Service Lights 20. Signature of Funcial Service	20b. Place of Di	sposition (Name of crematory or other place)		Oc. Location - City or To					
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21. Signature of Funeral Service Lights/e	n Kurf	22. Name and Address of Facility E. (z & Son F ille. Mar					
23a. Part 1. Enter the disease, or complications shock, or heart failure. List only one of immediate Cause (Final disease or condition	ations that caused he death. Do not cause on each line.	enter the mode of dying, such as cardiac co — Pan weah C			Approximate Interval Between Onset and Death				
Medical resulting in death) Examiner	Due to (or as a consequence of):	er 2	1- 4000						
Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events c.	Due to (or as a consequence of):		- 12 years						
	Due to (or as a consequence of):								
	•								
in the past 12 months?	FFEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy 1								
Division of Vital Records, P.O. Be a start dead by the funeral director. After this certificate has been signed by the funeral director, page 2 should be detached ed in by the funeral director, page 2 should be detached by the funeral director, page 2 should be detached examiner. Oertificate has been signed by the funeral director, page 2 should be detached examiner. 1 As 2 No No 27. Manner of Death 1 Natural 2 No 27. Manner of Death 1 No No No No No No No	buting to death but not resulting in the	ne underlying cause given in Part I.	23e. Did tobac	cco use contribute to the	he cause of death?				
Records, : The law require cate has been si; page 2 should k Completed		11.	24a. Was an autopsy performe	prior to co	psy findings available mpletion of cause of 2 No				
25. Was case referred to medical examiner? 1	pital:	26. Place of Death (Check	. /	·					
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27. Manner of Death 1 A Natural 5 Pending 2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No	28f. Location (Street and Number or Rural Route Number,						
DIVIS	building, etc. (Specify)		City or Town, S	itate)					
Division of Vital Reg To the Hospital or Attending Physician: The Regular or Attending Physician: The Regular or Attending Physician: The Regular or Attending Physician: The Regular or Attending Physician: The Regular or Attending Physician or Attendi	: On the basis of examination and/or in:	th occured at the time, date and place, and vestigation, in my opinion, death occurred at ge, death occurred at the time, date and place	the time, date and p	lace, and due to the car	use(s) and manner stated.				
29b. Signature and title of certifier	aclam N	29c. License number	30 290	Date signed (Month, 1)	Day, Year) 2011				
30. Name and address of person who comp	oleted cause of death (Item 23a) (Typo	Atwood, Belo	u 1	لال عاد	7114				
State Registrar 31. Date filed (Month, Day, Year) APR 0 5 2011	32. Registrar's Signature	KS							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State
Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Marc 1940 M DONALD MASON LARRIMORE 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Easton Talbot Memorial Hospita If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** 7. Age (In vrs. last birthday 8. Date of Birth Days (Month, Day,
JUNE 7, PENNSYLVANIA Director 175-32-8474 70 1940 Usual Residence of Decedent ms 23a or 28a-f show must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10a State 10c. City, Town or Location Director 1 Yes 2 No MARYLAND QUEEN ANNE'S CENTREVILLE 10e, Street and Number 10q. Citizen of What Country? 305 HAMMOND STREET UNITED STATES 21617 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. þ 1 Never Married 2 XMarried 1 ☐ Yes 2 ☐XNo If Yes, Give Maryland 21215-0036 1 ☐ Yes 2 XNo Specify: 3 Divorced Completed Specify: WHITE Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) AUTO MECHANIC AUTOMOTIVE Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည ROBERT RUSSELL LARRIMORE, JR. MARTHA TAYLOR 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DAWN EDWARDS/ DAUGHTER 22618 CAMRYN WAY, QUEEN ANNE, MARYLAND, 21657 Baltimore, 20a. Method of Disposition WOODLAWN MEMORIAL.ce MARCHate 21, 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 2011 **PARK** EASTON, MARYLAND 4 Donation 5 Other (Specify) 21. Signature of Funeral Service Licensee FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME P.A. 408 S. LIBERTY STREET, CENTREVILLE, MD 21617 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph sician/ Kesnicoto disease or condition hronic Medical resulting in death) Examiner Se juentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine page 2 should be detached for use as the burial-transit mphysens Due to (or as a consequence of) resulting in death) Last the attending physician Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Day Year Pregnant at time of death Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 2 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 🗌 No Yes 24 No 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 2 🗖 No Other: 1 Yes ျ 1 ≤ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Date of injury (Month, Day, Year) 27. Manner of Death ë 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death.

To the Funeral Director: After 5 Pending Natural Natural work? 1 ☐ Yes 2 ☐ No Certifical Accident Investigation Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 30. Name and address of person who complete Days of death (Kem 28a) (App. Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

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Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ JEROME LEROY MICHAEL, JR. MARCH 29, 2011 6:15P M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6278 HAWKINS GATE ROAD CHARLES LA PLATA Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 7. Age (In yrs. last birthday) 1 🛣 M 2 🗆 F Days 1/2-129-1928 82 WASH. D.C. Yrs **Director** 220-26-6726 Usual Residence of Decedent "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits Director MD. CHARLES LA PLATA 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 6278 HAWKINS GATE ROAD 20646 U.S.A. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, was Decedent Ever in U.S. Armed Forces? 1 XYes 2 □ No ARMY If Yes, Give 1951–53 Year or Dates. Black, White, etc. 1 Never Married 2X Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: WHITE 3 Widowed 4 Divorced Completed permit. Page 1 and 2 should be filed within 72 hour Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natu any injury or other traumatic event, the Medical any injury or other traumatic 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) COCA COLA-LA PLANT MANAGER <u>11th</u> 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) JEROME LEROY MICHAEL, SR. MARY ELIZABETH GREENE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CATHERINE MICHAEL-SPOUSE 6278 HAWKINS GATE RD. LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of 20c: Location - City or Town, State MD. VETERANS CEM. 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4-7-11 CHELTENHAM, MD. 4 Donation 5 Other (Specify) M00479 21. Signature of Ineral Service Licensee 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Onset and Death hem t Physician/ Is chemic disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (of as a consequence of). Exami To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 5 Other (specify) Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No မ 1 Inpatient 2 I ER/Outpatient 3 I DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending of Funeral Director: Af Ether of Funeral Director: Af Select of Illed in by the fu 1 🗌 Yes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exampler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier within 24 hor To the Fune completed fi (Check 3 Certifying Ny se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

Registrar

State

30. Name and address of person

ARR

31. Date filed (Morfin) Day, Year)

completed cause of death (Item 23a) (Type, Print)

32 Registrar's Signature

Jen/Co

D0033426

31

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Robert Potter Molten III Month 29 Day 2:33 P 2011 March Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death 22236 Ringgold Pike Washington Hagerstown Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year **Funeral** 7. Age (In yrs. last birthday 9. Birthplace (State or Foreign 1 🔀 M 2 🗆 F Months ^{Country)} F**lorida** Director 231-03-3377 94 Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director "natural", or items 23a or 28a-f s edical Examiner must be notified Maryland Washington Hagerstown 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21742 22236 Ringgold Pike U.S.A. death 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian. Armed Forces?
1
Yes 2 □ No Navy Black, White, etc. . Page 1 and 2 should be filed within 72 hours after of ment of Health and Mental Hygiene. The time 72 is marked other than "natural", or itury or other traumatic event, the Medical Examiniury or other traumatic event, the Medical Examinium þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify. 3 Widowed 4 Divorced WWII White Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business Industry Elementary/Seconday (0-12) College (1-4 or 5+) Mining Engineer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Robert Potter Molten, Sr. Elizabeth Gibbs Wylly 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22236 Ringgold Pike Hagerstown, Maryland 21742 (Daughter) Patricia M. Powell permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other ti 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State cemetery, crematory or other place) 1 Burial 2 X Cremation 3 Removal from State 31, March 4 ☐ Donation 5 ☐ Other (Specify) Smithsburg, Maryland Smithsburg Crematory 2011 Signature of Funeral Service Licensee 22. Name and Address of Facility J.L. Davis Funeral Home MO1414 12525 Bradbury Ave. Smithsburg, Maryland 21783 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ Curonary disease or condition Medical resulting in death) Examiner tive Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Physician/Medical Examiner Due to Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physician and eted filled in by the funeral director, page 2 should be detached for use as the burial-transit Due to (or as a consequence of): resulting in death) Last Division of Vital Records, P.O. Box 68760 IF FEMALE; 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months? Month Year Day 2 (No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 24 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performe 1 🗌 Yes 2 🗌 No Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 2 **Z** No မှ 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? Certificate: 28d. Describe how injury occurred Natural 5 Pending 1 ☐ Yes 2 ☐ No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifi D0050362 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 13424 Pennsylvania Are Suite antone 31. Date filed (Month, Day, Year) State APR 05 Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 800 AMIE Month 3 MACKELL 地川 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Anne Arundel Medical Annapolis Anne Arundel Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. Social Security Number 6. Sex Funeral 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign 1 □ M 2 F May 18 ^{/ear}1933 Maryland Director 213-32-0225 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1804 Robertsmall Rd. 21401 USA 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married δ 1 ☐ Yes : If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: should be filed within 72 hours after and Mental Hygiene. 3X Widowed 4 □ Divorced Completed B1ack Year or Dates permit. Page 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natur any injury or other traumatic event, the Medical I 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) 12th College (1-4 or 5+) 2yrs Ft. George Meade Secretary Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٥ Edward Offer Louise Williams 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Mackell(Son) 1804 Robertsmall Rd. Annapolis, Md. 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State 3 - 21 - 114 Donation 5 Other (Specify) Maryland Veteran Crownsville, Md. M. Marne and G. S. Pocilit Sons Mortuary, P.A. 21. Signature of Funeral Service Licensee 821 West St. Annapolis, Md. 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Immediate Cause (Final Physician/ STROKE disease or condition Medical resulting in death) Examiner ERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of): sician and burial-transit Physician: The law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last physician s the burial Physician/Medical 68760 attending p IF FFMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery Box in the past 12 months? Month Year Day Pregnant at time of death Yes 2 No 1 ☐ Yes ∠⊶eg ☐ Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? 2 🗌 No Yes 2 No 1 Yes 25. Was case referred to medical Division of Vital funeral director, Be 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 ☑ No Hospital Other: ျ Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) Hospital or Attending Pl 24 hours after death.
 Funeral Director: After the 28b. Time of 28c. Injury at 1- Natural 5 Pending work?
1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined within 24 hours To the Funeral Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of cert Ta lun 2m DEFENSE HWY ANNAPOLIS MOZIKUI Name and address of person who completed cause of death (Item 23a) (Type, Print) MICHAEL ENTE Jolal 31. Date filed (Month, Day, Year) State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Day Year ESTI 41150 2011 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Anne Arundel Medical Anne Arundel Center Annapolis 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 **X** M 2 □ F Days Hours Min. June 12 ^{/ear} 929 **Director** 213-28-4466 81 Maryland Usual Residence of Decedent "natural", or items 23a or 28a-f show adical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director Maryland Anne Arundel Annapolis 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1804 Robertsmall Rd 21401 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 X Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: Specify: 3 Divorced 4 Divorced Completed **Black** Year or Dates 1951-53 the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry Decedent's Usual Occupation (Give kind of work done during most of w. life. DO NOT use retired) Ground (Specify only highest grade completed) during most of working nd Mental Hygiene. marked other than United States Elementary/Seconday (0-12) College (1-4 or 5+) 12th 0 <u>Maintenance Supervisor</u> Naval Academy any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be file Department of Health and Mental I Important: If item 27 is marked o ပ Irving Mackell Sr Rebecca Washington 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Gregory Mackell(Son) 1804 Robertsmall Rd. Annapolis, Md. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Veteran ! 3 - 21 - 11Crownsville, Md. 21. Signature of Funeral Service Licensee MMame Roads Cof Pacility Sons Mortuary, P.A. 23a. Part 1. Ent. the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 821 West St. Annapolis, Md. Approximate Immediate Cause (Final disease or condition Inset and Death Physician/ Medical resulting in death) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Examin ysician and le burial-transit that the death certificate be executed Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical phys the b Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 5 Other (specify) signed by the a d be detached f Yes 2 No 1 L Yes 2 L 9 D Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Hospital or Attending Physician: The law requires in Eath ours after death.
24 hours after death.
Innerial Director: After this certificate has been sign sted filled in by the funeral director, page 2 should be Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed 2 🗀 No Yes 2 No 1 Tyes **Division of Vital** å 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2. No Hospital 1 🗌 Yes 잍 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident
3 Suicide
4 Homicide 1 Yes 2 No Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completed filled in by determined 24 hours a Funeral D Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2 Certifying Nurse Practioner: To interpret of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier W ed cause of death (Item 23a) (Type, Print) 31. Date filed (Month State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ Month Mar-705pm ^M Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death 1620 Hardwick Ct. Anne Arundel #203 Hanover Social Security Number If Under 1 Year If Under 24 Hrs. Age (In vrs. last birthday) 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** Months 1 🗆 M 2 🕱 F Days Hours Min (Month, Day, Year) 10/21/1907 Director 582-36-0199 103 Puerto Rico Usual Residence of Decedent r than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a. *** any injury or other traumatic access to the statement of t 10a. State 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes XX No MD Anne Arundel Hanover 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 1620 Hardwick Ct. 21076 #203 USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14, Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates White 1XXYes 2□No Specify: Puerto Rican 3 XXVidowed 4 Divorced Specify Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Severo Martinez Luisa Arnau 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Carmen Hatch daughter 1620 Hardwick Ct. #203 Hanover, MD 21076 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date 1 XBurial 2 Cremation 3 Removal from State 3/22/2011 Caguas, Puerto Rico 4 ☐ Donation - 5 ☐ Other (Specify) UNK Signature of Funeral Service Licensee 22. Name and Address of Facility Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of Examiner Sequentially list conditions, Examine cause. Enter Underlying Cause (Disease or linjury To the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 5 Other (specify) been signed by the should be detached Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has autopsy performe After this certificate Yes 2 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner? funeral director, Be 26. Place of Death (Check only one) Other: 1 ☐ Yes 2 No မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work 1 🗌 Yes 2 🗆 No Accident Investigation within 24 hours after deat To the Funeral Director: 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide determined Medical 29a. Certifier 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. completed (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 0 3a) (Type, Print) 30. Name and address of person who completed cause of death (

State

Registrar

31. Date filed (Month, Day, Year)

MAR 21

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Ann Raso Mahassel 18 4:15 P M March 2011 Medical **Examiner** 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Berlin Nursing Home Berlin Worcester Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In vrs. last birthday Birthplace (State or Foreign Country) 1 M 2 X F Days Hours 8/20/1 115-20-4106 Director 81 Yrs NY Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location should be filed within 72 hours after death with the Maryland must be notified at 10d. Inside City Limits Director 28a-f 1X Yes 2 □ No MD Worcester Ocean City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 307 139th St. 21842 USA 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. permit. Page 1 and 2 should be filed within 72 hours after deal Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or iten any injury or other traumatic event, the Medical Examiner. Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 3 ☑ Widowed 4 ☐ Divorced Year or Dates white 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 2 Owner/Operator Fire Arms Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Anthony Raso Maria Zangari 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Melina M. Bates / daughter 307 139th St., Ocean City, MD 21842 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 Burial 2 XCremation 3 Removal from State First State Crem. 3/21/2011 4 ☐ Donation 5 ☐ Other (Specify) Millsboro, 22. Name and Address of Facility Burbage Funeral Home 21. Signature of Funeral Service Lig 108 William St., Berlin, MD 21811 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause in each line. Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) ___ in the past 12 months?

1 Yes 2 XNo Day Year 4 ☐ Pregnant at time of death g ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🔀 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 ☐ Yes 2 ☐ No Yes 2 XN Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \(\subseteq \text{Yes} \) 2 \(\bar{X} \) No မ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral director. 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred injury work? 1 ☐ Yes 2 ☐ No 1 X Natural Accident 5 Pending Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Time Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) R 135131 March 21, Tirue 2011

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Registrar

Pennie

31. Date filed (Month, Day, Year)

32. Registrar's Signature

9715 Healthway Dr., Berlin, MD

CRNP,

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Savage,

MAR 22 201

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar ngni Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** Patricia Mosley 18, March 11:30 ₽ 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City. Town, or Location of Death Bel Pre Health & Rehabilitation Montgomery Silver Spring 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 🖫 F Months Days Hours 247-15-5377 56 Director 3,1954 S. Aug. Carolina Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other than "natural", or items 23a or 28a-f show any Injury or other traumatic event, the Medical Examination of the marman. 10a, State 10d. Inside City Limits 10b. County 10c. City. Town or Location Director LFM. Montgomery 1 Twes 2 □ No Silver Spring 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 2601 Bel Pre Rd 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 __Yes __2E__No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 1 Never Married 2 Married ∐Yes 2 Yes, Give 21215-0036 1 □Yes 2 No þ Specify: 3 ☐ Widowed 4 ☐ Divorced Black Year or Dates Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) 5College (1-4or 5+) Elementary/Secondary (0-12) Nurse Medical Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be James Mosley ပ Louise Wilson 19a. Informant's Name/Relationship (Type. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Williams / Aunt 6801 Bock Rd. Ft. Washington, Md. 20744 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Heritage Cemetery 3-24-11 4 ☐ Donation 5 ☐ Other (Specify) Waldolf, Md. 22. Name and Address of Facility Snead Funeral Home & Crematio. 21. Signature of Funeral Service Licenses 0777 5732 Georgia Ave. N.W. Wash. D.C.20011 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each the Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to for as a nonsequence of the Hospital or Attending Physiclan: The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, signed by the attending physician I be detached for use as the buria Physician/Medical IF FEMALE: yes, outcome of pregnancy
☐ Live birth 2☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mop Month Day Year Pregnant at time of death 5 ☐ Other (specify) ☐Yes 2 No 9 Unknown 9 I I Inknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □Yes 2 □No 24a Was an autopsy performed 1 Yes 2 No certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA this After thi funeral o 28a. Date of Injury (Month, Day, Year) 27. Manne of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 2 Accident death. s after death. 1 ☐ Yes 2 ∏No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) determined 4 ☐ Homicide To the Hospital o within 24 hours aff To the Funeral Di completely filled ir 1 retifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

DHMH 17 Rev 1/2001

31. Date filed (Month, Day, Year)

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west drive

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

O.

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Medical Grace Elaine Noble March 29 2011 9:20 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Northampton Manor Nursing Home Frederick Age (In vrs. last birthday 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign 1 🗆 M 2 💢 F Months Davs Hours 1934 Washington, D.C Director 577-42-8585 76 Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Direct 1 Yes 2 X No West Virgi. Jefferson Harper's Ferry 10e, Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 159 Country Road 25425 United States 11 Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian Armed Force If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 10. Black, White, etc 1 Never Married 2 Married þ within 72 hours after 1 Yes 2 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White "natural", Completed 3 X Widowed 4 Divorced Year or Dates. injury or other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) l Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Walter M. Porter Helen May Mickel 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jennifer Davy / Daughter 1012 Inkberry Way, Frederick, Maryland 21703 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State March^{Date}30. 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) cemetery, crematory or other place) Smithsburg Crematory 2011 Smithsburg, Maryland 21. Signature of Euneral Service Lice ise Keeney and Basford PA Funeral Home MO1473 106 East Church Street, Frederick, MD 21701 23a. Part 1. Enter the disease r complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final Onset a li eath Anemia emolytic Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and the burial-transi Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months?

1 Yes 2 No Ectopic pregnancy for Pregnant at time of death Month Year been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy perform 21 X No ☐ Yes completed filled in by the funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 - Residence 6 - Other (Specify) ည 1 🗌 Yes 2 No 1 Inpatient 2 I ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work Accident Investigation 1 Yes 2 🗌 No Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the best of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D43091 3-30-11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar Sacrol

31. Date filed (Month, Day, Year)

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DHMH 17 Rev 7/2009

32. Reistrar's Signature

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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Physicia	an/	Decedent's Name (First, Middle,Last)						2. Date o Month	Day	y Year	3. Time of Death 1205 hrs
al Exami	ner	TERESA ANN OLLES 4a. Facility Name (if not institution, give				th Oit Tour	n, or Location		27, 20	11 4c. County of Death	1205 1115
		Queen Anne's Emergency			I	Queensi		OI Death		Queen Anne's	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State									
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Maryland 28a-f shov d at once.	Director	10e. Street and Number	•			10f. Zip Co	de		10g C	Citizen of What Coun	try?
h the l'		301 TACKLE CIRCLE					21619			UNITED STA	
hours after death with the Maryland "natural", or items 23a or 28a-f sho Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Evaluation Armed Forces?					igin? (Specify Yes n, Puerto Rican, etc		14. Race - Americ White, etc.	can Indian, Black,
i, or i			1 Yes 2 X Yes, Give Year	No	1	Yes 2 X	No specify	r		Specify: WHI	ΓE
ours af	d by	15. Decedent's Education (Specify only	or Dates:	eted) 1		nt's Usual Occ	upation (Give	kind of work done	16b	b. Kind of Business/Ir	
7, , _	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)			nost of working					
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21215-0036 Juld be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last) JAMES MCTAGUE						r's Name (First, Mid		en Surname)	
2121; mild be fill Mental H marked		19a. Informant's Name/Relationship (Typ	e, Print)		19b. Mailin	g Address (RY ROBERT inber or Rural Rout		City or Town, State,	Zip Code)
MD 12 sho th and a 27 is		EDWARD A. OLLEK/ HI	JSBAND		P.O.	BOX 20	O, CHE	STER, MAR	RYLANI	D, 21619	
re, MC 1 and 2 s f Health ar f item 27		20a. Method of Disposition 1 Burial 2 X Cremation 3	Pomoval from State	20b. Pla	ce of Dispos	sition (Name o	of cemetery, ATION	MARCH 29	, 200	c. Location - City or	Fown, State
imore, MD 2 Pages 1 and 2 shoul nent of Health and M ant: If item 27 is m or other traumatic		4 Donation 5 Other Specify:	Removal from State		CEN			2011		TEVENSVILI	LE, MARYLANI
Baltimore, permit. Pages 1 a Department of He Important: If ite	ı	21. Signature of Funeral Service License	ee	•							HOME, P.A.
		23a. Part I. Enter the disease, or complic	rations that caused th	e death D						MARYLAND,	21619 Approximate Interval
hysician		failure. List only one cause on each	n tine.								Between Onset and Death
Examiner			Liver Cirr		comp	licati	ng Chr	onic Alco	hol E	Abuse	5000
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876 tificate ng phy as the l	M/C	IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome	of pregna		etal death	3 Ectopi	c pregnancy	2	23d. Date of delivery Month D	ay Year
Box 687 c death certific the attending p ed for use as th	icia	past 12 months? 1 Yes 2 No 9 Unknown	4 Pregnant at tin	ne of death	, - =	ther (Specify)					
O. Box 687 to the death certific d by the attending p	Physician/	Part II. Other significant conditions	9 Unknown	ut not soo	ding in the	underlying ag	es sivon in D	ort 1 220	Did tobaco	co use contribute to t	he cause of death?
Division of Vital Records, P.O. Box 687 To the Hospital or Attending Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending prompletely filled in by the funeral director, page 2 should be detached for use as the	<u>a</u>	Fait II. Other eignineant conditions	onlinding to death o	ut not rest	annig in trie t	underlying cac	ase giveirii r	1	_	No 3 Prob	
ords, P.C w requires that as been signed t	Completed							24a.	Was an	24b. Were aut	opsy findings available
COF	힐					<u>-</u>			autopsy performed	? death?	ompletion of cause of
Registrate		25. Was case referred to medical				26 P	lace of Death	(Check only one)	Yes 2	No 1 ✓ Yes	2 No
1 of Vital Rec Jing Physician: The I After this certificate I funeral director, page	o Be		spital: 1 Inpatient	2 ✓ EI	R/Outpatient		Othor	Nursing Home	5 Resi	idence 6 Other:	
of \ ug Phy ug reh under th	\vdash	27. Manner of Death	28a. Date of Injury (Month, Day,Year	, 2	8b. Time of I	Injury 28c.	Injury at Worl	k? 28d. Desc	cribe how i	injury occurred	
ion tendin eath. tor: A	agi a	1 X Natural 5 Pending 2 Accident Investigation		·		1[Yes 2	No			
Division of Vital Records, rat or Attending Physician: The law requirers after death. 1.1 Director: After this certificate has been sited in by the funeral director, page 2 should be	Certification:	3 Suicide 6 Could not be	28e Place of Injur	y - At hom	e, farm, stre	et, factory, off	ice building, e		tion (Streetwn, State)		al Route Number, City
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DIVISION To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	ledical	(Check only one) 2 Medical Examiner: C	 To the best of my k the basis of examir 								
To To Com	Med	29b. Signature and title of certifier	nd manner stated.				cense number			d. Date signed (Mon	
_		10/11/11	1 1	7	4	0	.C.M.E.		М	arch 28, 2011	
	1	30. Name and address of person who col	mpleted cause of dea	th (Item 23	32)					-	
			ant Medical Exa			n Street, E	Baltimore,	MD 21201			
St. Regist		31. Date filed (Month, Day, Year)	32. Registrar's	Signature	A. 16	back					

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March Pleasants 1 9 ay Edward Ashton 20ÏI 4:58 a^M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 5430 Indiantown Road Rhodesdale Dorchester 6. Sex 8. Date of Birth (Month, Day, Year) Dec . 9, 1925 **Funeral** 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 1 🕱 M 2 🗆 F Months Days Hours Country) Virginia 229-20-5968 **Director** Yrs 85 Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at Director 10c. City, Town or Location 10d. Inside City Limits MDDorchester Rhodesdale 1 🗆 Yes 2 🏝 No ö 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral items 23a 5430 Indiantown Road 21659 USA hours after death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black White etc. þ 1 Never Married 2 X Married 1 ☐ Yes 2 🛣 No If Yes, Give "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔽 No Specify: white Completed 3 Divorced 4 Divorced Il Hygiene. I other than "natura vent, the Medical E Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) truck driver transportation permit. Page 1 and 2 should be filed wit Department of Health and Mental Hygie Important: If item 27 is marked other any injury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 9 John T. Pleasants Merle Moss 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thomas L. Pleasants son 5430 Indiantown Rd., Rhodesdale, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State East New Market Cem. 3/23/11 4 ☐ Donation 5 ☐ Other (Specify) East New Market, MD e of Funeral Service Licensee Thomas Funeral Home P.A. 22. Name and Address of Facility 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each lin Interval Between Onset and Death Immediate Cause (Final Physician Cui disease or condition resulting in death) 00 Medical Due to (or as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Pregnant at time of death Month Day Year been signed by the should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an this certificate has page 2 autopsy performed Yes 2 After this certification funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 욘 1 🗌 Yes 2 No Other: 1 Inpatient 2 I ER/Outpatient 3 I 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manuar of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at work? 1 ☐ Yes 2 ☐ No 28b. Time of 28d. Describe how injury occurred Natural 5 Pending injury 2 Accident
3 Suicide
4 Homicide neral Director: A Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) within 24 hours a

To the Funeral D

completed filled i Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 100 OWE V 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ March 14, ¤2011 Рм Melvin Herman Posey 1:30 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Heritage Harbour Health & Rehab Anne Arundel Annapolis Social Security Number If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, March I **Funeral** 9. Birthplace (State or Foreign 1 X M 2 🗆 F Days Director 1924 Washington D.C. 579-26-7647 86 Usual Residence of Decedent 28a-f show 10a. State 10b. County the Maryland 10c. City, Town or Location ner must be notified at Director 1 Yes 2 X No Maryland Anne Arundel Annapolis 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? Funeral with 23a U.S.A. 985 Lanna Way 21401-6897 permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce. 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No Black, White, etc. Completed by 1 Never Married 2 Married 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates 1943-1945 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify: Specify: White 3 X Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of workir life. DO NOT use retired) 1e1ephone Elementary/Seconday (0-12) College (1-4 or 5+) Company Office Foreman Telephone Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Herman Posev Alice Virginia Willet 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>Gerald Connolly/ Step-Son</u> 9567 Tapok Drive #101, Manassas, VA 20110 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Baltimore-Washington 1 Burial 2 X Cremation 3 Removal from State 4 ☐ Donation □ ☐ 21. Signature of Funeral Service Licensee 3/17/2011 Laurel, Maryland rematory

22. Name and Address of Facility Robert E. Evans Funeral Home 16000 Annapolis Road, Bowie, Maryland 20715 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, Examine if any, leading to immediate
Cause (Disease or iinjury Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending havening and attending physician and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) Month Day Year Pregnant at time of death 1 Yes 2 9 Unknown 2 No been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an After this certificate has funeral director, page 2 s autopsy performed' 1 Yes 2 No Yes 2 25. Was case referred to dical examiner?

1 Yes 2 No completed filled in by the funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ၉ 1 Inpatient 2 ER/Outpatient 3 DOA 4 X Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural injury 5 Pending work?
1 Yes 2 No Accident Investigation 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examine: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year, 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar strar's Signature

MAR 1 8 2011

Division or Vital Records, P.O. Box 68760,

State Registrar

1835 University Blvd. #208 Hyattsville, 32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title o

31. Date filed (Monti

29c. License number

D0063681

29d. Date signed (Month, Day, Year)

Md.

2011

20783

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Physician/ LARRY LEE REA 7:04am arch 20 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Plata Medica Charles Civista La 9. Birthplace (State or Foreign MO • 5. Social Security Number If Under 1 Year If Under 24 Hrs 7. Age (In vrs. last birthday) 8 Date of Birth **Funeral** 1 ★ M 2 □ F 6-9-1945 65 488-48-1835 Director Usual Residence of Decedent show 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits ms 23a or 28a-f sho must be notified at Director MD. CHARLES LA PLATA 1 Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 9445 MAY DAY STREET 20646 U.S.A. permit. Page 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner musonce. 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14. Race - American Indian, Armed Forces?

1 X Yes 2 No ARMY
If Yes, Give RET SGT
Year or Dates. Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2X No Specify: SpecifyWHITE 21215-0036 3 Widowed 4 XDivorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) U.S.ARMY College (1-4 or 5+) Elementary/Seconday (0-12) U.S.GOVT. RET.FIRST SGT. 12th Be Baltimore, Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ JAMES BENJAMIN REA MARY BERNICE FEARNEYHOUGH 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DARLENE COX-FIANCEE 9445 MAY DAY ST. LA PLATA, MD. 20646 20a. Method of Disposition 20c. Location - City or Town, State ALEX., VA. 22. Name and Address of Facility
RAYMOND FUNERAL SERVICE, P.A.
LA PLATA, MARYLAND 20646 MQ0479 21. Signature of Funeral Service Licenses 23a. Part 1. Enter the disease, or complications that caused the death. Do not exter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Retween Onset and Death Immediate Cause (Final -Physician/ Inforction disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury and for use as the burial-tran that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death been signed by the should be detached 1 ☐ Yes ∠ ☐ 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 □ Yes 2 □ No 24a, Was an After this certificate has page 2 autopsy Yes 2 completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 1 ☐ Yes 2 🗹 No မ 1 ☐ Inpatient 2 É ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 1 ☐ Yes 2 ☐ No Certificate: 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Investigation 24 hours after death Funeral Director, Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nuyse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 To the I 29b. Signature and title of értifie 29c, License number 29d. Date signed (Month, Day, Year) 3/30/11 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ferraro Plata MD 20646

DHMH 17 Rev 7/2009

State Registrar

ORIGINAL

strar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienery For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ March Day 201^{Year} Gwendolyn Elizabeth Roulette 21 12:30 P M Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Washington Hagerstown Meritus Medical Center Social Security Number **Funeral** 7. Age (In yrs, last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 1 M 2 XX Min. Months oct. 2, 1927 Director 217-28-1228 Hours Yrs Maryland 83 Usual Residence of Decedent 28a-f shov with the Maryland Examiner must be notified at 10a State 10b. County 10c. City, Town or Location Director 10d. Inside City Limits Maryland | Washington 1 X Yes 2 No Hagerstown 10e, Street and Number "natural", or items 23a or 10f. Zip Code 10a. Citizen of What Country? Funeral permit. Page 1 and 2 should be filed within 72 hours after death with. Department of Health and Mental Hygiene. Important if item 27 is marked other there any injury or other traumation. 1183 Luther Drive 21740 IISA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. ş 1 Never Married 2 Married 1 Yes ZXXNo If Yes, Give Year or Dates. 1 ☐ Yes 2√1X No Specify: Completed 3XXWidowed 4 □ Divorced Specify: White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher Education Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Rhoda May Sprecher Elvin Roy Kendle 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ann Marie Downey - Daughter 11211 Kemps Mill Road Williamsport,MD 21795 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 XX urial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. View Cemetery 03-25-2011 Sharpsburg, Maryland Signature of Fu 22. Name and Address of Facility Osborne Funeral Home, P.A. S.Conococheague St. Williamsport, MD 21795 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death √Pnysician/ disease or condition Medical resulting in death) Examiner quantially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) signed by the atte in the past 12 months? Month Pregnant at time of death Day Year No Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Completed No 3 Probably 4 Unknown 1 Yes peen 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an has performed 2 🗆 No Yes 2 1 Yes • Hospital or Attending Physician: 24 hours after death. • Funeral Director: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) 1 Yes Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending injury work? 2 No Accident Investigation Suicide Could not be filled in by 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier npleted (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the within 7 29b. Signature and title of certifi 29c. License number 2011 . Name and address of person who completed cause of death (Item 23a) (Type, Print) 10 19 nth, Day, Year) 32. egistrar's Signature State 3 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Physician/ March 16 Day 201°1 5:40 Eugenia C. Ricker Ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 104 Park Avenue Edgewater Anne Arundel Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday 8 Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 T Hours Min 1272771936 **Director** 219-68-3224 54 MaryTand Usual Residence of Decedent show 10a. State 10b County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 Yes 2 No Maryland Anne Arundel Edgewater 10e. Street and Number ō 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 21037 United States 104 Park Avenue items within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian "natural", or þ 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 Divorced Completed Specify: White Year or Dates Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) marked other than Elementary/Seconday (0-12) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the N Registration Specialist Neighbor Works America Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Condore Patsy McComb 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 104 Park Avenue, Edgewater, Maryland 21037 Gregory A. Ricker/Husband 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) Lakemont Memorial Gardens 03/18/2011 Davidsonville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Road, Edgewater, MD 21037 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Pnysician/ Canac Ung disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and Cause (Disease or impury that initiated events tran and Due to (or as a consequence of) resulting in death) Last burialthe attending physician hed for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death Month 5 Other (specify) Day Year 2 No g 🗌 Unknown 9 Unknown s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown cate has been s page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed' 1 Yes 2 No Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital Other: Certificate: To 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Accident Investigation 6 Could not be filled in by the Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State Medical 29a Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Cartifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only on 29b. Signatu 29d. Date signed (Month, Day, Year) 3/16/11 065272 mpleted cause of death (Item 23a) (Type, Print) VH 210 200 31. Date filed (Month, Day, Year State MAR 1 8 2011

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Day Month Year 0330 PROTHU 2011 Medical 4a. Facility Name (if not institution), give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 2714 Parkview Rd. Riva Anne Arundel Social Security Numbe Birthplace (State or Foreign Country)
 Ohio If Under 1 If Under 24 Hrs. 8 Date of Birth **Funeral** 1 M 2 F Months Days Min 1/10/1925 Director 274-20-6847 Usual Residence of Decedent ms 23a or 28a-f show must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2XXNo Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? Funeral 2714 Parkview Rd. 21140 USA permit. Page 1 and 2 should be filed within 72 hours after death w Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items; any injury or other traumatic event, the Medical Examiner mus 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces?

1 Yes 2 No
If Yes, Give þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 X Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Teacher's Aide Childcare Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Harris Thomsen Emma Unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Robert R. Rill/Son 920 Buttonwood St. Apt. B9 Norristown, PA 19401 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Cremation 3 ☐ Remov rom State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 3/22/2011 Crownsville, MD of Funeral Service Licenses 22. Name and Address of FacilityGeorge P. Kalas Funeral Home alas 2973 Solomons Island Rd. Edgewater, MD 21037 23 x F rt 1. Enter the discase, or complica hock, or heart failure. List only one of ns that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Onset and Death Immediate Cause (Final UKEMIA Physician/ disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Exam that the death certificate be executed Cause (Disease or linjury that initiated events burial-tran Due to (or as a consequence of) resulting in death) Last physician the burial Physician/Medical Box 68760 attending p IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?

1 Yes 2 No Month Year Pregnant at time of death Day signed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, The law requires 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of page performe 2 🗌 No Yes 2 V No Physician: Division of Vital funeral director. Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital 2**√** № Other: 1 \square Yes 유 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 🗷 Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Pt within 24 hours after death.

To the Funeral Director: After it completed filled in by the funeral 27. Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1X Natural 5 \square Pending work? 2 Accident
3 Suicide
4 Homicide 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To be best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifit 29d. Date signed (Month, Day, Year) D 21438 445 Defense Hay Annapolis Mis 21401 leted cause of death (Item 23a) (Type, Print) State 8 2011

DHMH 17 Rev 7/2009

Registrar

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Medical Exami	ner			ene Rick		III						Ma	arch 17,	, 2011		l	2313 hrs
		4a. Facility Name (Atlantic Ger			number)		4	b. City, Berli		r Locati	on of Dea	th			County of Vorceste		
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	Director	1000 Ed	lgewat	er Ave.	Uni	t 502		28	142					US	А		
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Division of Vital Records, P.O. Box 68760, tal or Attending Physician: The law requires that the death certificate be after death. 11 Director: After this certificate has been signed by the attending physicial in the funeral director, page 2 should be detached for use as the buri	Certification:	1 Natural	5 Pend	ing FOUN	th Day,Year) D:	FOUN	D:	_,	_	Yes 2	_				om fifth f		balcony
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ELIZABETH VIRGINIA SCHULTZ MARCH 30,2011 8:20A M Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 10235 LA PLATA ROAD LAPLATA CHARLES Social Security Number If Under 1 Year 7. Age (In yrs. last birthday) If Under 24 Hrs 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Days Months 1 □ M 2 🔀 F Hours 212-30-8302 83 Yrs. 810nth, 5ay, Year 27 MD ountry) **Director** Usual Residence of Decedent ral", or items 23a or 28a-f shov Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland ment of Health and Mental Hygiene.

ant. If item 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Directo MD. CHARLES LA PLATA 1 XYes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 10235 LA PLATA ROAD 20646 U.S.A. 11. Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Forces Black, White, etc. þ 1 Never Married 2 Married ☐ Yes 2 ☐XNo Baltimore, Maryland 21215-0036 1 Yes 2 X No Specify: If Yes, Give Specify: WHITE Completed X ☐ Widowed 4 ☐ Divorced Year or Dates. artment of Health and Mental Hygiene. ortant: If item 27 is marked other than "natui injury or other traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) FARMERS TOBACCO Elementary/Seconday (0-12) College (1-4 or 5+) WAREHOUSES AUCTION SECRETARY/BOOKKEEPER Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ JOHN WILLIAM GREER, SR HANNAH CARPENTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) JANE SCHULTZ COLLINS-DAUGHTER P.O.BOX 2506 LA PLATA, MD. 20646 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ot 20c. Location - City or Town, State X Burial 2 ☐ Cremation 3 ☐ Removal from State ST. MARY CEMETERY 4-9-11 BRYANTOWN, MD. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee M00479 RAYMOND FUNERAL S LA PLATA, MARYLAND 23a. Part 1. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ disease or condition Medical resulting in death) Due to (r as a consequence of) Examiner Sequentially list conditions Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) the attending physician and ned for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
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Registrar

DHMH 17 Rev 7/2009

State

31. Date filed

KAHAKSHI BAIG H.D., 6620 CRAIN HWY, LAPLATA, HD

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

5

32. Registrar's Signature

11-02307 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. David Spencer State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Medical Examiner March 24, 2011 1608 hrs DAVID BRYAN SPENCER 4a. Facility Name (if not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death St. Mary's St. Mary's Hospital Leonardtown 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year I ff Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or **Funeral** 440-76-3536 Months Days 3-18-1965 Director 46 1 M 2 F Country) Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits MD. CHARLES LA PLATA 1 Yes 2 X No or 28a-f show , or items 23a or 28a-f shor Director 10e Street and Number 10f Zip Code 10g, Citizen of What Country 11650 ENGLEWOOD DRIVE 20646 U.S.A. Funeral 11 Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, tant: If item 27 is marked other than "natural", or items or other traumatic event, the Medical Examiner must be Baltimore, MD 21215-0036
permit. Pages I and 2 should be filed within 72 hours after death v
Department of Health and Mental Hygiene.
Important; If item 27 is marked other than "natural", or item Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 Never Married 2 X Married 2 X No Yes SpecifWHITE 4 Divorced If Yes, Give Year 1 Yes 2 No specify: Ŕ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) DCS CORP. AVIONICS ENGINEER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maioen Surname) FRANKLIN LEON SPENCER Be JANET KAY DAVIDSON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11650 ENGLEWOOD DR. MALISSA SPENCER-SPOUSE LA PLATA, MD. 20646 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State ATEANTICE CREMATORY 3 - 27 - 11GLEN BURNIE, MD. 4 Donation 5 Other Specify. 21. Signature of Funeral Service Licensee M0047 Name and Address of Facility RAYMOND FUNERAL SERVICE, P.A. LA PLATA, MARYLAND 20646 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death a Hypertensive Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and transit Physician/Medical **X** UNPENDED attending physician for use as the burial -23a,pt.II,27,g915 5-18-11 sm certificate be Box 68760, IF FEMALE 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Fetal death Month Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown ned by the a detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, P.O. 23e. Did tobacco use contribute to the cause of death? 包 1 Yes 2 No 3 Probably 4 V Unknown Sleep Apnea, Obesity page 2 should be 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of death? performed? 1 🗸 Yes ✓ Yes 2 No 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 2 PER/Outpatient 3 DOA Other Nursing Home 5 Residence 6 Other 1 Yes No 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification 1 X Natural 1 Yes 2 No Pending

Division of Vital

After this certificate has within 24 hours after death To the Funeral Director: filled in by the

Accident

Suicide

Homicide

31. Date filed (Month, Day, Year)

Investigation

(Specify)

Could not be

29a. Certifier (Check only 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 🗸 and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) O.C.M.E. March 25, 2011 OCME 30. Name and address of person who completed cause of death (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

28f. Location (Street and Number or Rural Route Number, City

or Town, State)

State Registrar

Medical

28e. Place of Injury - At home, farm, street, factory, office building, etc.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ Dav 10:30 PM Gary James Sullivan Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Calvert Burnett - Calvert Hospice House Prince Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth Months | Days | Hours | Min. | (Month, Day, 5. Social Security Number 6. Sex g. Birthplace (State or Foreign 7. Age (In yrs. last birthday, **Funeral** 1 🙀 M 2 🗆 F 0370971948 Mary land **Director** 579-56-4126 63 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 X Yes 2 No MD Calvert Chesapeake Beach 10e. Street and Number 10g. Citizen of What Country? Funeral U.S.A. 3814 12th Street 20732 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. Completed by 1 Never Married 2 Married 1 Yes 2 X No Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No Specify: Specify: white 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) self employed printer printer Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Sullivan Roxanna Berndgen Gerard Audrev 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Roper, Daughter 24575 West Montiego Road, Hollywood, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Speciff) Metropolitan Crematory 03/25/2011 Alexandria, VA 22. Name and Address of Facility Rausch Funeral Home, P.A. Signature of Funeral Service Vicent 8325 Mt. Harmony Lane, Owings, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Pinal Onset and Death Physician/ P rw cancer disease or condition 4.0055 Medical resulting in death) Due to (or se a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or in jury that initiated events Examiner Due to (or as a consequence of): Hospital or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) Live Birth 2 Live Gard Co.
Pregnant at time of death in the past 12 months? Day Month Year 1 Yes 2 g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à re- circhosis 1

Yes 2 □ No 3 □ Probably 4 □ Unknown Completed filled by the funeral director, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?

1 Yes 2 No After this certificate 1 Yes 2 No To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 Yes 2 No Other:
4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Certificate: 28a. Date of injury (Month, Day, Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at X Natural 5 Pending work 1 Yes 2 No To the Hospital or Attendi within 24 hours a er decth To the Funeral Director A completed filled i by the fi Accident Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 📈 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Gains aput March 16, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Ti Frany Gaines GRUP, 238 Merriman Cliprince Fredrick MD DOVER

State Registrar 31. Date filed (Month, Day, Year)

MAR 2

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiener State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Matrich 322 M Danya Lenee Strevia Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Health Medical Hagerstown Washington Center . Social Security Number If Under 1 Year If Under 24 8. Date of Birth 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2XCX Hours 10726y Baltimore, MD 219-38-9004 69 1941 **Director** Usual Residence of Decedent "natural", or items 23a or 28a-f shov edical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b, County 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 □ No Hagerstown Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 17112 Paps Ln. Apt. 5 21740 USA Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Completed by Yes 2 XXO Baltimore, Maryland 21215-0036 Specify: white 1 Yes 2 No Specify: 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) medical 12 lab tech Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ James Leonard Hepner Stella Marie Cave 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Terry Morgan-Decker/dtr 17103 Paps Ln. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 XXurial 2 ☐ Cremation 3 ☐ Removal from State Martinsburg, Rosedale Cemetery 3/26/2011 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Hoense 22. Name and Address of Facility Rosedale Funeral 25404 917 Cemetery Rd. Martinsburg, WV 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ Acute Res Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the Innerial director, page 2 should be detached for use as the burial-transit roneho premenon Due to (or as a co sequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy performed death? 2 No 1 🗌 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending ☐ Accident ☐ Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29d. Date signed (Month, Day, Year) ne and address of person wha completed cause of death (Item 23a) (Type, Print)

Registrar
DHMH 17 Rev 7/2009

dIMIR

nth, Day, Year)

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shmanin

Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ Month Year June Marlene Shank 10:00 AM 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Meritus Medical Center Washington County Hagerstown Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex 7. Age (In yrs. last birthday) Funeral Sep. 17, 1935 1 □ M 2 XF 234-34-7591 75 Maryland Yrs Director Usual Residence of Decedent show 10b County permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shor any injury or other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Tes 2 No Maryland Washington County Hagers town 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 15562 Wishard Rd. 21740 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 X No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc 1 Never Married 2 XMarried Completed by 1 Yes 2 If Yes, Give Year or Dates Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Personal Residence Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Lester Clopper Cora Rudisill Clopper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charles E. Shank-husband 15562 Wishard Rd. Hagerstown, MD 21740 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 X Burial 2 Cremation 3 Removal from State Rest Haven Cemetery | 3-23-2011 4 ☐ Donation 5 ☐ Other (Specify) Hagerstown, Maryland 21. Signature of Funeral Service Liçensee 22. Name and Address of Facility Douglas A. Fiery Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the moshock, or heart failure. List only one cause on ach line. Eastern Blvd. North Hagerstown, MD 21742 Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the lumeral inversion, page 2 should be detached for use as the burial-transit that initiated events resulting in death) Last Completed by Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months? Dav 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Tes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an performed 2 110 Yes 2 100 1 Yes 25. Was case referred to medica Be 26. Place of Death (Check only one) examiner? 2 [No Other: 1 Yes ပ္ 1 Impatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at work? 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical

Baltimore, Maryland 21215-0036

Box 68760

Division of Vital Records,

DHMH 17 Rev 7/2009

Registrar

29a. Certifier

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FRANCISCO L. ANDRADE

Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29d. Date signed (Month, Day, Year)

29c. License number **D 2 7898**

350 MILL ST. HAGERSTOWN MD

3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

1-02076		Please Type or Print in Black Indelible Ink. Ensure All Copic		gible.		
Bradley Emanue	S		lygiene	2011	10920	
		Registrar Certificate of Death		g. No.		
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Bradley Emmanuel Sunkins Jr.	2. Date of Deat Month March 16,	Day Year	3. Time of Death 1738 hrs	
		4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 301 Lori Drive #I Glen Burnie	4c. County of Death Anne Arundel			
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	s. B. Date of Bir		thplace (State or	
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A		Usual Residence of Decedent 10a. State 10b. County 10c. City. Town or Location			404 (
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215-0036 be filed within 72 hours after death with the Maryland and Hygiene. rked other than "natural", or items 23a or 28s-f sho ent, the Medical Examiner must be notified at occe.	Director	301 Lori Drive #I 21061		ISA	wy:	
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Baltimore, MD 2's pemit. Pages I and 2 should Department of Health and M Importact: If item 27 is millory or other traumatite.					7	
E Debu De	-	21. Signature of Funeral Service Legissee 22. Name and Address of Facility Co.: 1822 Portsmouth BI:			23704	
Physician /Medical		23a/Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and	
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BO)	Physician/Med	1 Yes 2 No 9 Unknown 9 Unknown				
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Vital Rec	8	25. Was case referred to medical examiner? 26. Place of Death (Check examiner? 1 Ves 2 No Other 1 Norsinal: 1 Inpatient 2 ER/Outpatient 3 DOA Other 1 Norsinal: 1		Residence 6 🗸 Other		
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Division At ours after deeral Direct filled in by		4 Homicide determined (Specify)	or Town, St	ate)		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attendiog Physiciae: The law requires that the death certificate be within 24 hours after death. To the Fuerral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	ga	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a				
To the within Comp.	Medica	2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and-manner stated. 29b. Signature and the of certifier 29c. License number	une, uate a	29d. Date signed (Mon		
	_	O.C.M.E.		March 17, 2011	, Day, real)	
	-	30. Name and address of person who completed cause of death (item 23a)				
		Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201			
Sta Registi		31. Date filed (Month, Day, Year) AAR 3 0 2011 32/Registrar's Signature				
DHMH 17 Rev 1/20	_	OPIGINAL				
OCME 2006	- 1	OCME ORIGINAL				

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 11-02029 State of Maryland / Department of Health and Mental Hygiene Robert John Tippitt 1- For State Certificate of Death Registrar 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle,Last) Physician/ March 14, 2011 1418 hrs Medical Examiner John Tippitt Robert 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Washington Hagerstown 18630 Donald Street If Under 24Hrs. B. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Davs Hours Country) AK Director 4/19/1956 179-48-4713 1X M 2 F Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 11 J 10a State 10b County 1 Yes 2 No Hagerstown 28a-f show Washington MD permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other tranmatic event, the Medical Examiner must be notified at oace. Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21742 USA 18630 Donald Street 14. Race - American Indian, Black, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-12 Was Decedent Ever in U.S. 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. Armed Forces? 1 X Never Married 2 Married 1 Yes 2 X No Specify: White 1 Yes 2 X No specify: 4 Divorced If Yes. Give Year 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Printing Industry Printer 12 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Tippitt Faust Frances James E . 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Barclay Drive Bedford, Pa. Tippitt Frances 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Burial 2 X Cremation 3 Removal from State Keystone Crematory 3/19/201 Tyrone, PA. Donation 5 Other Specify 22. Name and Address of Facility Timothy A. Berkebile Funeral Home 21 Signature of Funeral Service Licensee 15522 Juliana Street Redford, Pa Approximate Interval 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear **Physician** Between Onset and failure. List only one cause on each line /Medical Chronic Alcohol Abuse with Cirrhosis of the Liver Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) ner if any, leading to immediate cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit 23a,27 per me g914 4-26-11 vt Physician/Medical X UNPENDED AMENDED Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE 23b. Was decedent pregnant in the Day Year 3 Ectopic pregnancy Month 1 Live birth 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? 2 No ✓ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Be Other Nursing Home 5 Residence 6 Other Scene

Division of Vital

Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA 1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pending

6 Could not be

determined

28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work?

1 Yes 2 No 28e. Place of Injury - At home, farm, street, factory, office building, etc

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

28f. Location (Street and Number or Rural Route Number, City

29d. Date signed (Month, Day, Year)

28d. Describe how injury occurred

or Town, State)

and manner stated 29c. License number 29b. Signature and title of certifier headere M. K. OCME.

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

March 15, 2011

Russell Alexander MD.

Suicide

Homicide 29a. Certifier 1

Name and address of person who completed cause of death (Item 23a)

32. Registrar's Signature

Medical

State Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month MARCH Physician/ РΜ Norma Blanche Trovinger 2011 3:48 Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner Washington Boonsboro Reeder's Memorial Home If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Month Day, Ye.
April 24 Months 1 🗆 M 2 🗶 F Washington D.C. 65 217-42-9639 Director Usual Residence of Decedent show 10d. Inside City Limits 10c. City, Town or Location permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shon any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County Director 1 X Yes 2 No Sharpsburg Maryland | Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21782 USA 218 West Chapline Street Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 12. Was Decedent Ever in U.S. 11. Marital Status Armed Forces Black White etc. 1 Never Married 2 X Married 1 ☐ Yes 2 If Yes, Give Completed by Baltimore, Maryland 21215-0036 ☐ Yes 2 No Specify: Specify: White 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 16b Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Clothing Manufacturing Seamstress Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Mina Virginia Wilson Unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Sharpsburg, MD 21782 Richard N. Trovinger, Jr.-Husband 218 W. Chapline St. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a, Method of Disposition ☐ Burial 2 X Cremation 3 ☐ Removal from State Hagerstown Crematory 03-24-2011 Hagerstown, Maryland 4 Donation 5 Other (Se 21. Signature of Funeral S 22. Name and Address of Facility Osborne Funeral Home, P.A. Þ Williamsport, MD 21795 S.Conococheague St. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Physician/ HOVANUED TERMINAL DEMENTIA ments disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner MULTIPLE 4 em CONTRACTURE Sequentially list conditions Examiner Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying FAILURE MONETUS Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury TO THRWE and for use as the burial-tran that initiated events Due to (or as a consequence of) resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 Yes 2 No Month Day Year Pregnant at time of death signed by the al d be detached fo ed by the 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 🕻 Unknown 1 Yes has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed?

1 Yes 2 No 1 ☐ Yes 2 🖟 No After this certificate 25. Was case referred to medical examiner?

1 Yes 2 No funeral director, Be 26. Place of Death (Check only one) Hospital: Other: ပ Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: injury 1 Natural 2 Accident 5 Pending after death. Director: Af 1 ☐ Yes 2 ☐ No Investigation the 6 Could not be Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or Atte within 24 hours after de To the Funeral Directo completed filled in by the 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29c. License number 29d. Date signed (Month, Day, Year) 29b, Signature and title of certifie MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD 21713 301-432-8470 <u>Ghazala Qadir</u> 20311 Lappans Road Boonsboro. egistrar's Signature State Registrar

DHMH 17 Rev 7/2009

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Physicia	ın/	Registrar 1. Decedent's Name (First, Midd	ile,Last)					2. Date of Dea		3. Time of Death
Medical Exami		William Ray T	URNER					March 19,	, 2011	1945 hrs
		4a. Facility Name (if not institute 51 Madison Avenue	on, give street and nu	ımber)	ľ	lb. City, Town, or L Hagerstown	ocation of Death	1	4c. County o Washing	
Funeral		5. Social Security Number	6. Sex	7. Age (In vrs	. last birthday)	If Under 1 Year	If Under 24Hrs	s. 8. Date of Bir	_	9. Birthplace (State or
Director			1 X M 2 F	7.0		Months Days	Hours Min		18 1941	Foreign Country) Maryland
_	H	212-38-9808 Usual Residence of Decedent	1 M 2 F	70) fis		<u> </u>	Teb.	10 1741	
ku l	ı	10a. State 10b. County		10c. Cit	y, Town or Locati	on				10d. Inside City Limits
uyland Sa-f show It once.	اڃا	Maryland Wash	ington		Hagers	stown				1 X Yes 2 No
faryla	Director	10e. Street and Number		10f. Zip Code		1	at Country?			
ith the Maryland 23a or 28a-f sho notified at once.	히	51 Madison Avenue 21740							USA	
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r deat	뒨	1 Never Married 2 N	1 Yes	2 X No		_				
s afte	<u>a</u>	3 Widowed 4 X Dir 15. Decedent's Education (Spe	vorced If Yes, Give Yes			Yes 2 X No		work done	Specify: 16b. Kind of Bus	White
2 hour	E E	Elementary/Secondary (0-12)				ost of working life. [TOD. Kind of bus	in 1653/11 (ddStry
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21215-0036 wild be filed within 7 Mental Hygiene. marked other than e event, the Medica	Completed	17. Father's Name (First, Middle			1 111			First, Middle, I	Maiden Surname)	ortation oo.
215 be file mtal H rked	a	Thomas L. Tu	rner, Sr.					A. Rick		
D 21 hould hould Me is ma	-1	19a. Informant's Name/Relations				Address (Street				
MD and 2 show m 27 is summation		George Turne 20a. Method of Disposition	r - Broth	er		7 Marsh 1		agerstow Date		and 21742 City or Town, State
or He, of He, If ite		1 X Burial 2 Crematio			crematory or oth					,
Page Page ment cant:		4 Donation 5 Other S		F		L Cemeter				town, Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Heathh and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once		21. Signature of Funeral Service	Licensee			ame and Address of				
	-	23a, Part I, Enter the disease, or	r complications that o	aused the deal						Maryland 21740
Physician W⊶dical Examiner		failure. List only one cause Immediate Cause (Final disease or condition resulting in death)	on each line.	ve Atheros	clerotic Cardi	ovascular Dise				Between Onset and Death
			b.	consequence	OI).					
	힐	Sequentially list conditions, if any, leading to immediate	Due to (or as a	consequence	of):					
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Box 6876(death certificate the attending phy-	Physician/Me	23b. Was decedent pregnant in t past 12 months?		oirth nant at time of o	dooth -	al death 3	Ectopic pregna	ancy	Month	Day Year
lox 6 leath cer	/sic	1 Yes 2 No 9 Un	known 9 Unkn		death 5 Otl	ner (Specify)			0.400	
D. B t the d by the		Part ii. Other significant condi			resulting in the u	nderlying cause giv	ven in Part I.	23e. Did to	obacco use contrib	oute to the cause of death?
Division of Vital Records, P.O. ral or Attending Physician: The law requires that the rs after death. **I Director: After this certificate has been signed by the funeral director, page 2 should be detached in by the funeral director, page 2 should be detached.	ğ							1 Yes	s 2 No 3	Probably 4 V Unknown
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Vital Recc ysician: The lav his certificate ha director, page 2	Be	examiner? 1 Ves 2 No	Hoenital:	Inpatient 2	ER/Outpatient		When m		Residence 6	Other: Scene
ing Phy After th	٤	27. Manner of Death	28a. Date	of Injury , Day,Year)	28b. Time of I	njury 28c. Injury	at Work?	28d. Describe	how injury occurre	d
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Division of Vital Records, P.O. Box 68760 To the Bospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the b		29a. Certifier 1 Certifying P	hysician: To the besign	st of my knowle	edge, death occur	red at the time, date	e and place, and	due to the caus	se(s) and manner	as stated.
To the How within 24 h	Medical		aminer: On the basis and manner s	u examination tated	and/or investigat			at the time, date		
	Σ	29b. Signature and title of certifi	el Man	1		29c, License				d (Month, Day, Year)
TF		Alle Br	and NB			O.C.M	1.⊆.		March 20, 2	
الذ		 Name and address of person Melissa Brassell, MD 	who completed cause Assistant Me		•	enn Street, Ba	altimore MD	21201		
	212			gistrar's Signa		om oneer, Da	AIGINOTE, IVID	_ 1201		
St Regist	ate	31. Date filed (Month Rev. 72%)	ZUIT	- Company	A. Aug	ALL STREET				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 10924 For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month 3 Physician/ 2011 0530A M RUTH MARIE THOMAS Medical 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** RACIONALMALICAL If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Sex 1 M 2 T 7. Age (In yrs. last birthday) DEC. 5, 1918 Months Hours Min. 228-09-1220 92 Yrs VΑ Director Usual Residence of Decedent 28a-f shov 10a. State 10b. County "natural", or items 23a or 28a-f sho 10c. City. Town or Location 10d. Inside City Limits Director VA ACCOMACK ATLANTIC 1 X Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 23303 32472 NOCK'S LANDING ROAD USA 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian 11. Marital Status Yes, specify Cuban, Mexican, Puerto Rican, etc. Armed Forces? Black, White, etc. 1 Never Married 2 Married þ Maryland 21215-0036 1 Yes 2 X No Specify. If Yes, Give Year or Dates Specify: WHITE 3 ¥ Widowed 4 □ Divorced Completed traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation
(Give kind of work done during most of working 16b. Kind of Business Industry I Hygiene. life DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 1 and 2 should be filed with f Health and Mental Hygien item 27 is marked other th SELF EMPLOYED OWNER RETAIL STORE Be 17. Father's Name (First, Middle, Last, 18. Mother's Name (First, Middle, Maiden Surname) ပ ROY LEE TYNDALL CELIA MEARS 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 38 - ATLANTIC, VA RONNIE THOMAS (SON) permit. Page 1 and 2 Department of Health Important: If item 27 any injury or other tr Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 4/2/2011 TEMPERANCEVILLE, VA JOHN W. TAYLOR CEM. 22. Name and Address of Facility THORNTON FUNERAL HOME, INC. CARL U. THORNTON 24183 CHADBOURNE ST. - PARKSLEY, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Physician/ Oronen disease or condition resulting in death) Medical Due to (or as a consequence of Examiner ardismy Sequentially list conditions trany, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to for as a consequence of Exami burial-transit and that initiated events resulting in death) Last Due to (or as a consequence of) attending physician for use as the burial Physician/Medical that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Pregnant at time of death Other (specify) the 9 Unknown 9 Unknown signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an To the Hospital or Attending Physician: The law within 24 hours after death.

To the Funeral Director: After this certificate has be autopsy performe ☐ Yes 2 📉 1 Yes 2 No 25. Was case referred to medical funeral director. 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Anatural injury work?
1 Yes 5 Pending 2 🗆 No ☐ Accident☐ Suicide Investigation filled in by the 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier completed. (Check only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 26 2011 MARCH 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CARROLL St. SAlisbury md. E. HEARN mi 31. Date filed (Month, Day, Year) APR 0 5 2011 State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ A:40 PM Betty 03 2011 Jane Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Washington Haberstown Julia Manor Health If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number **Funeral** (Month, Day, Year) oct. 25,1930 1 □ M 2 🖺 F Days Hours Min. Maryland 80 215-26-1947 Oct. Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural?" any injury or other traumatic events. 10d. Inside City Limits 10a. State 10c. City, Town or Location Director 1 X Yes 2 No Hagerstown Maryland Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21740 USA 839 Chestnut Street 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 🔀 No If Yes, Give <u>ک</u> 1 Never Married 2 Married white 1 ☐ Yes 2 K No Specify: Specify: 3 X Widowed 4 Divorced Completed Year or Dates 16a, Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) ribbon mfg. ribbon spooler Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ Emma Catherine Robinson Clyde Nelson Shaffer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) P.O. Box 87, Sharpsburg, Maryland 21782 Peggy Myers - daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) IX Burial 2 ☐ Cremation 3 ☐ Removal from State Hagerstown, Maryland Cedar Lawn Mem.Park 3/26/2011 4 Donation 5 Other (Specify) MINNICH FUNERAL HOME Signature of Funeral Service Licenses 22. Name and Address of Facility 415 E. Wilson Blvd., Hagerstown, Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ Sinork disease or condition Medical resulting in death) Examiner Sequentially list conditions, Examiner Due to (or as a consequence of). if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury or Attending Physician: The law requires that the death certificate be executed been signed by the attending physician and should be detached for use as the burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) .___ in the past 12 months?
1 \(\sum \) Yes 2 \(\sum \) No Month Dav Year Pregnant at time of death 1 ☐ Yes ≥ 1 9 ☐ Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by ierebral Vasiular Accident, Vascular Dementia 1 ☐ Yes 2 ☐ No 3 X Probably 4 ☐ Unknown Osteoarthritis, Consestive Heart 24b. Were autopsy findings available prior to completion of cause of death? cate has page 2 s autopsy Yes 2 X No 1 Yes 2 No this certificate 25. Was case referred to medical 26. Place of Death (Check only one) examiner?
1 \sum Yes Hospital 2 🔀 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 28c. Injury at work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 X Natural injury 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 3)24/11 ho completed cause of death (Item 23a) (Type, Print) Blucher - 33

Registrar DHMH 17 Rev 7/2009

State

Barbara Naden

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Wisner march Kenneth F. 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death four Hagers ash if Under 1 Year | If Under 24 Hrs. Funeral Social Security Number 8. Date of Birth 9. Birthplace State or Foreign Country) MD Months Days Hours 1**火** M 2 □ F 1072771929 81 Director 216-22-1629 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No PA Fulton McConnellsburg 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral 17233 USA 1096 East Lincoln Way Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. 1 Never Married 2 Married δ 1 Yes 2 X No 3altimore, Maryland 21215-0036 1 ☐ Yes 2 👿 No Specify. If Yes, Give Specify: White 3 Divorced Completed Year or Dates traumatic event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Social Services 4 Accountant Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 1 and 2 should be file of Health and Mental Hitem 27 is marked of 2 Wisner Evelyn Joseph Wisner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tr 8365 Rd. Waynesboro, Pa.17268 Shank Hess Pau1 Wisner (Son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State MeadowBranch Cem.:3/19/2011 Westminster, Md. 22. Name and Address of Facility Howard L. Sipes Funeral Home 21. Signature of Funeral Service License 875 LincolnWay E. McConnellsburg, Pa. 1723 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final Physician/ meumonia disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate oduce. Enter Uncertains Cause (Disease or iinjury Due to (or as a consequence of) death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last burialattending physician for use as the burial Physician/Medical Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death 1 Yes 2 L 9 Unknown the 9 Unknown P.O. I s been signed by the should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 ☐ Yes 2 🔯 No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☐ No 24a Was an sate has bage 2 s autopsy performed certificate 2 X N Hospital or Attending Physician: Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 \(\) Nursing Home 5 \(\) Residence 6 \(\) Other (Specify) 1 Yes 2 XNo ၉ 1 Nnpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred After 1 Natural 5 🗌 Pending work? n 24 hours after death.

Ne Funeral Director: A' pleted filled in by the fu 2 🗌 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 within 2 only one Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 30. Name and address of berson who completed cause of death (Item 23a) (Type, Print) WH-6 YEAR e Mer 31. Date filed (Moat

DHMH 17 Rev 7/2009

State Registrar Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician/ MARCH 11, 2011 10:45 PM ARNOLD ERNEST WOLF Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** KENT CHESTERTOWN NURSING & REHABILITATION CHESTERTOWN If Under 9. Birthplace (State or Foreign 8. Date of Birth Social Security Number **Funeral** 1 XM 2 □ F Months Days Hours 01/10/1931 MARYLAND Director 213-28-3815 Usual Residence of Decedent ral", or items 23a or 28a-f show Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. The Marker 1. 10a. State 10c. City, Town or Location 10d. Inside City Limits 10b. County Director 1 X Yes 2 No QUEEN ANNE'S OUEENSTOWN 10e Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 121 TAYLOR DRIVE 21658 UNITED STATES 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian Armed Forces?

1 XYes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: If Yes, Give Year or Dates Specify: Completed 3 Widowed 4 □ Divorced WHITE 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) SHIPYARD FOREMAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ CHARLES JOHN WOLF, JR. GERTRUDE ESTELLA UNKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TAYLOR DRIVE QUEENSTOWN, MARYLAND 21658 MICHAEL G. HOXTER / STEP-SON 20a Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 03/18/2011 HURLOCK, MARYLAND MD VETERAN CEMETERY Signature of uneral Service Licenses 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME, P.A.
106 SHAMROCK ROAD CHESTER, MARYLAND 21619 23a, Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between
Onset and Death
DAYS shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ RENAL INSUFFICIENCY disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner SYSTEMIC LUPUS 5 YEARS Sequentially list conditions, if any body gradient cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last Examine Due to jor as a consequence of Physician: The law requires that the death certificate be executed attending physician and for use as the burial-tran Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) Ectopic pregnancy in the past 12 months? Month Dav Year Pregnant at time of death ate has been signed by the page 2 should be detached g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by VENOUS INSUFFICENCY, SEPSIS 1 Yes 2 XNo 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2**X** No After this certificate 1 ☐ Yes 2 ☐ No 25. Was case referred to medical completed filled in by the funeral director. Be 26. Place of Death (Check only one) examiner?
1 Yes 2 X No Hospital Other: မ 4 XNursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of Hospital or Attending Pl 124 hours after death.
 Funeral Director: After the Certificate: 28c. Injury at 28d. Describe how injury occurred 1 X Natural injury work 5 Pending Accident
Suicide 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined To the Hospital of within 24 hours a To the Funeral D Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nesse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29b. Signature and title o 29d. Date signed (Month, Day, Year) 3 90051735 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6602 CHURCH HILL ROAD, SUITE 200, CHESTERTOWN, MD 21620 FREDERICK DELBOY, MD. 31. Date filed (Month, Day, Year) 32. Registrar's Signature MAR 1 8 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death 2 Date of Death Physician/ March 18 20°11 9:40 рм Jack Stewart Willey Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Cambridge Dorchester Chesapeake Woods Center If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 5. Social Security Number 8. Date of Birth 6 Sex 7. Age (In yrs. last birthday) **Funeral** Maryland Dec. 4, 1931 1 XM 2 1 220-26-7981 79 Director Usual Residence of Decedent show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 27 is marked other than "natural", or items 23a or 28a-f sho traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No MD Dorchester Cambridge 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 1003 Glasgow Street 21613 Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married 1 ☐ Yes 2 🕱 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 Widowed 4 X Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life, DO NOT use retired) (Specify only highest grade completed) 1 and 2 should be filed within 72 if Health and Mental Hygiene. item 27 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) draftsman wire cloth mfg. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frank Willey Mary Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Tami W. Parisi 4221 Long Green Rd., Glen Arm, MD daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Date permit. Page 1 a Department of H Important: If ite any injury or otl 1 X Burial 2 Cremation 3 Removal from State Dorchester Mem. Park 3/22/11 Cambridge, MD 4 Donation 5 Other (Specify) 22. Name and Address of Facility Thomas Funeral Home P.A. 21. Signature of Funeral Service Licensee 700 Locust St., Cambridge, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final disease or condition Onset and Death Constrovascul Priysician/ Medical resulting in death) Examiner Sequentially list over fitters if any, leading to immediate cause. Enter Underlying Exami Cause (Disease or linjury sician and burial-trans that initiated events resulting in death) Last Due to (or as a consequence of) attending physician Physician/Medical requires that the death certificate be Box 68760 the as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy ō in the past 12 months?
1 Yes 2 No Month Day Pregnant at time of death signed by the air g Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an or Attending Physician: The law autopsy has death? certificate 1 Yes 2 Ne Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital 1 🗌 Yes 2 1 NO 욘 1 Inpatient 2 ER/Outpatient 3 DOA 4 Harsing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After this completed filled in by the funeral direction. 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred □ Matural 5 Pending injury 1 ☐ Yes 2 ☐ No Investigation Accident 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier □ Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
□ Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar

31. Date filed (Month, Day, Year)

MAR 23 2011

30. Name and address of person who completed

1HNWY 503 BYRN ST 32/Registrar's Signature

ause of death (Item 23a) (Type, Print)

CAMBRIDAR MD 21613

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, State Registrar Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Physician/ 130 P.M. Williams heri dan marc 20 Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Examiner Queen Chester Riverside mive (In yrs. last birthday)
Yrs. If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth **Funeral** Country Mary land (Month, Day, Days Hours 1 📉 M 2 🗆 F 212-22-4050 Director Van. Usual Residence of Decedent er than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits 10b. County 10c. City, Town or Location death with the Maryland Director 1 ¥ Yes 2 ☐ No he ster 10f. Zip Code 10g. Citizen of What Country? Funeral 21619 Riverside 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Was Decedent Ever in U.S 11. Marital Status Armed Forces' Yes 2 No 1943 Yes, Give Black White, etc. 1 Never Married 2 Married within 72 hours after Completed by Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Blac 3 Widowed 4 Divorced 1946 Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Specify only high grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) permit. Page 1 and 2 should be filed within Department of Health and Mental Hyglene. Important: If item 27 is marked other than any injury or other traumatic event; the Mental France of the count. Elementary/Seconday (0-12) Postal Service Handler 124h Be 18. Mother's Name (First, Middle, Maiden Surname, 17. Father's Name (First, Middle, Last) Williams 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Chester Dorothy 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 23 Wood lawn Cemeters Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses NID 21613 23a. Part V. Enter the disease, or complications that caused the death. Do not enter the mode of dying, Approximate Interval Between shock, or heart failure. List only one caus Onset and Death Immediate Cause (Final disease or condition Ph, sician/ Medical resulting in death) Due to (or as a consequence of): Examiner S Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last to (or as a consequence of) Examine sician and burial-transit Due to (or as a consequence of): attending physician for use as the buria Physician/Medical that the death certificate be Box 68760 IF FEMALE: yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No Year Month Day Pregnant at time of death ed by the a Unknown P.O. 23e. Did tobacco use contribute to the cause of death? signed I 5 To the Hospital or Attending Physician: The law requires 2 No 3 Probably 4 Unknown Division of Vital Records, Completed cate has been się , page 2 should b 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 201 within 24 hours after death.

To the Funeral Director: After this certificate I completed filled in by the funeral director, page 1 Yes 2 🗌 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? 2 X No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) ၉ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Certificate: work? 1 \(\subseteq \text{Yes} \quad 2 \(\bar{\text{\$\subset}} \) No 1 Natural 5 Pending Accident
Suicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of c n 23a) (Type, Print) cause of death 61 140 31. Date filed (Month, Day, Year) State MAR 23 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month ^{Day} 2011 Physician/ Patricia Ann Anderson 9.20 P M April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Shining Moon Assisted Living Towson 1 Year | If Under 24 Hrs. Davs Hours | Min. Social Security Number 9. Birthplace (State or Foreign . Age (In yrs. last birthday) 8. Date of Birth **Funeral** 1 🗆 M 2 🖾 F Months (Month, Day, Yea Maryland Director 219-40-7468 67 1943 May Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits filed within 72 hours after death with the Maryland Director Maryland n/a Baltimore City 1 X Yes 2 No 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? Funeral U.S.A. 21214 2720 Louise Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status 14 Race - American Indian Armed Forces? Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White If Yes Give 1 ☐ Yes 2 🔀 No Specify: 3 X Widowed 4 □ Divorced Completed Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) McCormick 10 yr's Package Handler Be 17. Father's Name (First, Middle, Last) Department of Health and Mental H Important: If Item 27 is marked any injury or net 18. Mother's Name (First, Middle, Maiden Sumame) Haggerty Peggy Ann Bahner Daniel Dennis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs Tina Line - daughter 2720 Louise Ave. Baltimore, MD 21214 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🛭 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Donation 5 Other (Specify) 4/8/11 Baltimore, MD Parkwood Signature of Funeral Service Licensee 22. Name and Address of Facility Baltimore, Maryland 21214 Harr Ruck Inc. 5305 HArford Rd Leonard J. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each one. Approximate Interval Between Onset and Death Immediate Cause (Final STROKE Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner 3 years neum aniA Sequentially list conditions. Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed Jause (Disease of ili gur) that initiated events resulting in death) Last Due to (or as a consequence of): attending physician for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Dav Year Pregnant at time of death 5 Other (specify) 4 ☐ Pregnant 9 ☐ Unknown 1 Yes 2 L 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed certificate has been sirector, page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 2 🗌 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 4 Nursing Home 5 Residence 6 Other (Specify) 1351548 Living Other: Certificate: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural Accident Suicia 5 Pending neral Director: A filled in by the fu 1 Tes 2 🗌 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier D50760 Whysic an 30. Name and address of person who ompleted cause of death (Item 23a) (Type, Print) LuTheralle. M.0

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

0 6 2011

32. Registrar's Signature

			-	pe or Print in Black In						
		-	For State Registrar	State of Maryland / Depa Cea	artment of Health rtificate of Deat		ental Hygien Reg. N	2011	10931	
			Decedent's Name (First, Middle, Last)			2	2. Date of Death Month Da	ay Year	3. Time of Death	
	Physicia /Medic	-		Sandra Ann Auch			April	1 2011	7;51A M	
)	Examin	-	4a. Facility Name (If not institution, give str	reet and number)	4b. City, Town, or Locatio	on of Death	4	c. County of Deat	h	
			2907 Richie Aven	ue	Edgeme				ore Co.	
Q.	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday)	If Under 1 Year If Und Months Days Hours		 Date of Birth (Month, Day, Year 	r) 9. Birtl	hplace (State or Foreign untry)	
	Director		214-40-1002	M 2₩ F 67 Yrs.			Aug. 25,1	943 Mar	yland	
	and w		Usual Residence of Decedent 10a, State 10b, County	10c. City, Town or Lo	ecation				10d. Inside City Limits	
	faryla sho ed at	ō	FL Pinella	c Co	Pinellas	Park			1 ☐ Yes 2 😿 No	
	the N	ect	10e. Street and Number	3 001	10f. Zip Code	IGIK	10g. C	itizen of What Co	untry?	
	with la or		9790 66th Street	North Lot 316		3782	Uı	nited St	ates	
	death with the Maryland	Funeral Director		Was Decedent Ever in U.S. 13	Was Decedent of Hispanic	Origin? (Spec	ify Yes or No-	14. Race - Ame		
_	r iter	F	1 ☐ Never Married 2 ☐ Married	1 ☐ Yes 2- No	If Yes, specify Cuban, Mexi		ican, etc.)	Black, White	e, etc.	
Š	urs a al", o Exan	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2,€5tNo <i>Sp</i> ec	ату.		Specify:	White	
9500-6121	72 hc	Completed	15. Decedent's Educa	completed) (Give	dent's Usual Occupation kind of work done during m	most of working	16b.	Kind of Business/	Industry	
7	ithin or . Mer	du.	Elementary/Secondary (0-12) 12 Years 2	College (1-4or 5+)	DO NOT use retired)		TI o o	1+b C	December of the second	
N	led w tygien her ti		12 Years 2	Teals Cert	ified Nurse		tant Health Care Provider e (First, Middle, Maiden Surname)			
and	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "natural", or items 23a or 28a-f show sumatic event, the Medical Examiner must be notified at	Be	Leonard I. Fox	•	V	olet	M. Rice	,		
Mary	should nd Me mark matic	2	19a. Informant's Name/Relationship (Type		ng Address (Street and Nur			or Town, State, 2	Zip Code) 21740	
	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 Is marked any Injury or other traumatic esone.		Karla D. Auch (Dau		l Broadfordi					
ē,	item item		20a. Method of Disposition	20b. Place of Disponentery, cre	osition (Name of matory or other place)	Da	ate 20c.	Location - City or	Town, State	
Ē	Page nent c		1 ☐ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State Hilltop	Service Corp	4/6/	2011 To	wson, Ma	ryland	
Baitimore,	permit. Departn Importa any Inju		21. Signature of Funeral Service Licenses		2. Name and Address of Fa Ouda-Ruck Fun	acifity neral H	ome of Du	ndalk, I	inc.	
D	2012		Jest a los		7922 Wise Av	e. Dun	dalk, Mary		1222 Approximate	
	3			ations that caused the death. Do not en	1		1.		Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Hypertensive Ar	terro schero	tic Laz	dicoascula	r Viseas	۷	
	Examiner			to (or as a consequence of):						
		er	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence ot):						
	secuted and -transit	xamine	that initiated events							
ó	<u>a</u> .⊇ 6	ш	resulting in death) Last	Due to (or as a consequence of):						
98760	The law requires that the death certificate be exite has been signed by the attending physician bage 2 should be detached for use as the buria	Physician/Medical	d.							
	ertifica ing pl	Med	IF FEMALE:	-		7-1				
Box	ath ce ttendi	jan/	23b. Was decedent pregnant in the past 12 ponths?		Ectopic pregnancy		11.9	23d. Date of de Month	livery Day Year	
0	w requires that the death been signed by the atte should be detached for	/sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at time of death 5 9□Unknown	Other (specify)					
٦.	that the sed by detac		Part II. Other significant conditions cont	ributing to death but not resulting in the	art I.	23e. Did tobacco use contribute to the cause of dea				
Vital Records,	uires sign	d b					1 ☐ Yes	2 □ No 3 □ P	robably 4 Unknown	
Ö	w req been shou	Completed					24a. Was an	24b. Were a	utopsy findings available	
Æ	sician: The law certificate has l irector, page 2 s	mp		· · · · · · · · · · · · · · · · · · ·			autopsy performed:	prior to death?	completion of cause of	
g			25. Was case referred to medical		26 P	Place of Death	(Check only one)	No 1 ☐ Yes	s 2000	
	s cert	o Be	examiner?	ospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	Other		ne 5 Residence	6 XOther (Spe	ecity) Sisters 4 ame	
ō	g Physer this eral dir	7: To	27. Manner of Death	28a. Date of Injury 28b. Time			8d. Describe how in		100000000000000000000000000000000000000	
<u>o</u>	ndlng tth. r: Afte e fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	M 1 ☐ Yes 2	2□No				
Division or	Atte er dea recto by th	ifica	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of injury - At home, farm, s building, etc. (Specify)	treet, factory, office	2	8f. Location (Street City or Town, St	and Number or Fl ate)	lural Route Number,	
	tal or safte	Certification:		N .						
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical ((Check only 2 Medical Examin	ician: To the best of my knowledge, dea er: On the basis of examination and/or i	th occurred at the time, dat nvestigation, in my opinion,	te and place, a , death occurre	and due to the cause ed at the time, date	e(s) and manner a and place, and du	s stated. le to the cause(s)	
	thin 2 the 1 the 1 mplet	Medi	29b. Signature and little of certifier	and manner stated.	29c. License numb			Date signed (Mon		
\	F × F 8		I Literal A	1. 6 11	101	(7			201	
,		_	30. Name and address of person who cor	moleted cause of death (Item 22a) (Tune	Print)	4	AT	27,11,	2011	
			Philip Milite	11 4171-12	£'	Luthe	wille, M	90156	3	
	Sta		31. Date filed (MoAth, Day, Year) APR 0 6 2011	32. Registrar's Signature	1					
	Registi	ar	AFR U O ZUII	energy p. parks						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ APR I 2011 1:50P LEONARD C. AKMAN Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner GILCHRIST HOSPICE CARE TOWSON BALTIMORE If Under 1 Year If Under 24 Hrs. 8. Date of Birth g. Birthplace (State or Foreign Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 X M 2 □ F Months Days Hours Country) 577-12-1514 06/03/1919 Yrs 91 DC **Director** Usual Residence of Decedent or 28a-f shov 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits event, the Medical Examiner must be notified at Director 1 Yes 2 No BALTIMORE BALTIMORE 10e. Street and Number 10g. Citizen of What Country? Funeral items 23a 2805 GRASTY WOODS LANE 21208 USA filed within 72 hours after death 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Armed Forces' Black, White, etc. by 1**XX**Never Married 2 ☐ Married ō Maryland 21215-0036 1 ☐ Yes 2 X No Specify. WHITE Specify. If Yes, Give Completed 3 Divorced 4 Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) and Mental Hygiene. is marked other than Elementary/Seconday (0-12) College (1-4 or 5+) 5+ CARDIOLOGIST MEDICINE Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ CHARLES AKMAN SONIA EISENBERG t. Page 1 and 2 should be rtment of Health and Men rtant: If item 27 is marke njury or other traumatic traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ALVIN AKMAN/COUSIN 2900 STONE CLIFF DRIVE, #209 BALTIMORE MD 21209 Saltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 🗶 Burial 2 🗆 Cremation 3 🗆 Removal from State Department of Important: If any injury or once. 04/05/2011 4 Donation 5 Other (Specify) EBANON CEMETERY ADELPHI 22. Name and Address of Facility SOL LEVINSON & BROS., 21. Signature of Funeral Service Licen 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** Sequentially list conditions. Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death Linknown g Unknown P.0 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Certificate: To Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an has autonsy 2 🗌 No 1 Tyes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending M 1 Tyes 2 🗌 No Investigation 2 Accident Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) 29b. Signature and title of pertifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 21204 KUMAR 701 31. Date filed (Month, Day, Year) 32. Registrar's

DHMH 17 Rev 7/2009

Registrar

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			Amend Item 20 Please	b per fh,g Type or Prin	914,04/0 ht in Blac	07/2011d k Indelibl	hb e lnk. Ens	ure All Copie	es Are Legible).	
			Amend Item 20 Please an - State Amend Items Registraramend 28e,	State of Ma 28a,b,e pe per me,g920	ryland / [r me,g9] 10-17-	iepartmen 14,04/04 O <i>ęrtijic</i> ate	of Health /2011ahb of Death	and Mental H	ygiene Reg. N. 0	10933	
	Physicia		Decedent's Name (First, Middle, La	ilw Jess				2. Date of D Month		3. Time of Death	
	Medic Examin		4a. Facility Name in not institution, giv		lical Cen		Town, or Location	of Death	4c. County of Dea		
	Funeral	П	5. Social Security Number 6.		(In yrs. last birth				irth 9. Bi	irthplace (State or Foreign ountry)	
	Director	_	212-29-3432 Usual Residence of Decedent 10a. State 10b. County	<u> </u>	20 Y			1 104 0	2 1990	MD 10d. Inside City Limits	
	Marylan 28a-f sh otified a	Director	MD NA			timore				1 Yes 2 No	
	with the 23a or s		10e. Street and Number 1553 Langford	Road		10f. Zip	Code 21207		10g. Citizen of What C		
920	e filed within 72 hours after death with the Maryland ital Hygiene. ed other than "natural", or items 23a or 28a-f show event, the Medical Examiner must be notified at	ed by Funeral	11. Marital Status 1 X Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 IN If Yes, Give Year or Dates.		If Yes, speci	ent of Hispanic Ori	igin? (Specify Yes or No n, Puerto Rican, etc.)	14. Race - Am Black, Whi Specify: B	ite, etc.	
21215-0036	within 72 houn giene. er than "natu , the Medical	Completed	15. Decedent's (Specify only highest g Elementary/Seconday (0-12) 11th grade		-)	Decedent's Usual Give kind of work ife. DO NOT use Unemplo	: done during mos retired)	at of working	16b. Kind of Business Unempl	1	
Maryland	12 should be filed within the and Mental Hygiene. 27 is marked other tha r traumatic event, the N	.0	17. Father's Name (First, Middle, Last) Derrick Gillard	<u> </u>				er's Name (First, Middle sa Burges			
Mar	d 2 shou alth and 1 27 is m er traum		19a. Informant's Name/Relationship (Teresa Burgess		19b. 15	Mailing Address	Street and Number	er or Rural Route Numb oad, Balt	er, City or Town, State, Z imore, Md	^{lip Code)} 21207	
Baltimore,	permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau		20a. Method of Disposition 1	Removal from State	ce Onter	Disposition (Name Simple or other Memoria	her place)	3/ 22/2011 2/21/201	20c Location - City of Baltimore	r Town, State	
Balt	permit. Depart Import any inj		21. Signature of Eureral Service Licen	arh		March 4300 V	Address of Facili F/H We Vabash	št Ave, Balt	imore, Md	21215	
			23a. Part 1. Enter the disease, or conshock, or heart failure. List only of Immediate Cause (Final	one cause on each line.	6	t enter the mode	of dying, such as	cardiac or respiratory a	arrest,	proximate Interval Between Onset and Death	
C	Medical Examiner		disease or condition resulting in death)	a. Di to (or as a		E SHO	<u>l</u> wount	d to the	- /		
	ed	Examiner	5 squentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury	Due to (or as a	consequence of):		1/11	D BY WEDICAL EXAM	NEW .	
0	be executed sician and burial-transit	_	that initiated events resulting in death) Last	Due to (or as a	consequence of):	TEETIFICATION ROPROND BY WEDICAL EXAMINER				
Box 68760	To the Hospital or Attending Physician: The law requires that the death certificate be ex within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician completed filled in by the funeral director, page 2 should be detached for use as the burial	by Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome o 1 Live Birth 2 4 Pregnant at 9 Unknown	Fetal death	3 ☐ Ectopic pr 5 ☐ Other (spe			23d. Date of do	elivery Day Year	
rds, P.O	equires that the sen signed bould be deta	ted by P	Part II. Other significant conditions of	contributing to death bu	t not resulting in	the underlying ca	ause given in Part		tobacco use contribute t	o the cause of death?	
ا مرمسر الح Vital Record	The law re cate has be page 2 sh	Be Completed						24a. Was auto peri 1 □ Yes	opsy prior to formed death?		
Vital	ysician: s certific director,	To Be	25, Was case referred to medical examiner? 1	Hospital:	nt 2 🗆 ER/Outr	patient 3 🗆 DO	Othor	th (Check only one)	idence 6 ☐ Other (Spe	c(fy)	
£ 4	ding Ph th. After thi funeral	cate: 1	27. Manner of Death 1 Natural 5 Pending	03/13/20	1 28b. Tir inj		c. Injury at work?	28d. Describe		nghot	
$\beta \neq \mathcal{E}$ Division	al or Atten s after dea al Director: ed in by the	Certificate:	2 Accident Investigatio 3 Suicide 6 Could not to 4 Homicide determined	e 280 Place of Injur	v - At home, fam	n, street, factory,		28f. Location City or To	(Street and Number or Ruyn, State)	ural Route Number, We Baltimore,	
00	e Hospital or 124 hours afte e Funeral Dire lleted filled in I	Medical	(Check 2 L Medical Exam	iner: On the basis of exa	amination and/or	eath occured at thinvestigation, in m	ne time, date and y opinion, death o	place, and due to the courred at the time, date	ause(s) and manner as st and place, and due to the he cause(s) and manner as	cause(s) and manner stated.	
	To the withir comp		29b. Signature and title of certifier	e,MD)	29c.	License number)	29d. Date signed (<i>Monto</i>	th, Day, Year)	
	(3)		30. Name and address of person who LINGXIANG	IE	ath (Item 23a) (Ty			e Street		e, MD2120j	
	Stat Registra		31. Date filed (Month, Day)*(ear) MAR 18		's.Signature	faces)	ĵ				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Physician/ 823P M ARRY DREY 201 prel Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore 520 Stevenson Lane 7. Age (In yrs. last birthday) 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 058-22-6868 Months Days Hours Min 05/22/1928^{Year)} 1 - M 2**XX** F **Dellaware** Director Usual Residence of Decedent r 28a-f show notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director 1 ☐ Yes XX No Maryland Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 ral", or items 23a or Examiner must be Funeral 21286 USA 520 Stevenson Lane 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14 Race - American Indian 11. Marital Status Armed Forces? Black, White, etc. ģ 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2XX No Specify: nan "natural", Medical Exan If Yes, Give Year or Dates White Completed ¾X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) should be filed within 72 and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) the Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Clarence Thornton Mary McMichael traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other train. Son 520 Stevenson Lane Towson Maryland 21286 James R Barry 3altimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place, 20c. Location - City or Town, State ☐ Burial 2XX Cremation 3 ☐ Removal from State |GreenMount Crematory 04/12/11 Baltimore, Maryland ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home Inc nature of Funeral Serv 6500 York Road Baltimore, Maryland 21212 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ ANCED PAR disease or condition Medical resulting in death) as a consequence of): **Examiner** Sequentially list conditions, Due to or as a consequence of Examine if any leading to immedicause. Enter Underlying burial-transit Cause (Disease or linjury that initiated events and Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical certificate be P.O. Box 68760 as the t IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent preg 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ for in the past 12 month Pregnant at time of death Month Day Year signed by the a 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by PANCREATIC Records, 1 Yes 2 No 3 Probably 4 Unknown page 2 should peen OBSTRUCTIVE PULMENARY DISAGE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy has this certificate CORONARY 1 Yes 2 No 2 Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Certificate: To Be examiner?
1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify, 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 5 Pending work? 1 ☐ Yes 2 ☐ No 1 ANatural Accident
Suicide Investigation Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🗜 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 3 29c. License number 29b. Signature and title of certifie 636 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 32. Registrar's 6 Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiens - State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Apri 9:40 AM 2011 Medical 4b. City, Town, or Location of Death 4c. County of Death Eacility Name (if not institution, give street and number) Examiner christ Baltimore Towsor Social Security Number 8. Date of Birth SEPF 27 6. Sex Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Hours Min. 1 □ M 2 👿 Months Director Usual Residence of Decedent of Mental Hygiene. marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location be filed within 72 hours after death with the Maryland Director timore 1 Yes 2 No 10g. Citizen of What Country? 10e. Street and Number Woodlea Funeral 21206 12. Was Decedent Ever in U.S. Armed Forces? . Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes If Yes, Give 2 No Maryland 21215-0036 Blac 1 Yes 2 No Specify. Specify: 3 Widowed 4 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) narmaci Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Man traumatic Page 1 and 2 should and Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or ural Route Number, City or Town, State, Zip Code) <u>s</u> Health tem 27 anvale altimore item 2 Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State o Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ 月 to more, Metro 4 Donation 5 Other (Special 22. Name and Address of Facility Towell f Funeral Service Balto MD 2120 Heights 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions. Examine if any, leading to immediate cause. Enter on denying Cause (Disease or linjury Due to (or as a consequence of): attending physician and for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of): resulting in death) Last attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ Month Year Pregnant at time of death 1 Yes 2 1 Unknown 9 Unknown be detached signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 2 No 3 Probably 4 Unknown completed filled in by the funeral director, page 2 should I been 24b. Were autopsy findings available prior to completion of cause of 24a. Was an certificate has autopsy perform death? 1 Yes 2 No Yes 2 1 No 25. Was case referred to medical examiner?

1 Yes 2 10 Be 26. Place of Death (Check only one) မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Nother (Specify) After this 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 5 Pending 1 Natural injury work? 1 🗆 Yes 2 🗌 No death. Accident
Suicide Investigation 24 hours after deat Funeral Director. 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check within 2 To the I only one) Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certific 29c. License numbe 04 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ARATHT SUITE WILL BALTIMOR KINAR CHARIES 32. Registrar Signature State Registrar

11-02501

8

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Deborah Bauer 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Da April 1, 2011 0900 hrs Medical Examiner Bauer Deborah 4c. County of Death 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Baltimore** Bayview Hospital N/A If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** oreign Hours Days Director June 5,1956 MDCountry) 54 216-66-3051 1 M 2 X F Yrs Usual Residence of Decedent 10d. Inside City Limits 10b. County 10a. State 10c. City, Town or Location 1 Yes 2 XXNo Edgemere 28a-f shnw Baltimore Baltimore, MD 21215-0036
permit Pages I and 2 should be filed within 72 hours after death with the Maryland
Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", nr items 23a or 28a-f shn
injury nr inther traumatic event, the Medical Examiner must be notified at once. 10a. Citizen of What Country? 10f. Zip Code 10e. Street and Number South Cove Road 7740 United States 21219 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11 Marital Status 12. Was Decedent Ever in U.S. If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 Never Married 2 1X Yes 4 X Divorced If Yes, Give Year or Dates: 1 Yes 2X No specify: Specify: White 3 Widowed é 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) College (1-4 or 5+) United States Elementary/Secondary (0-12) Government Investigated Services Years 12 Years 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) æ Lulu Mae Herndon Charles N. Farmer, Jr. 19a. Informant's Name/Relationship (Type, Print) Stepfather 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21013 Baldwin, Maryland 2703 Terra Vista Drive Charles J. Arkins 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) Burial 2 Cremation 3 Removal from State Hilltop Service Corp. 4/8/2011 Towson, Maryland Donation 5 Other Specify: 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc.
Duda-Ruck Funeral Home of Dundalk, Inc. 21 Signature of Funeral Service Licensee 3a. Part I. Enter the Jase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva Physician Between Onset and failure. List only one cause on each line /Medical Death Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical AMENDED 23a, pt.II, 27 per me g914 4-7-11 vt X UNPENDED attending physician or use as the burial Box 68760 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Year 1 Live birth 3 Ectopic pregnancy 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 ✔ Unknown for 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, P.O. ğ 1 Yes 2 No 3 Probably 4 V Unknown Oxycodone use, Cirrhosis of Liver Completed should b 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy certificate has performed? . death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient 2 PER/Outpatient 3 Other Nursing Home 5 Residence 6 Other DOA ဥ 1 🗸 Yes 28c. Injury at Work? 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 1 Yes 2 No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be 3 Suicide or Town, State) determined 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier O.C.M.E April 2, 2011 Hallow 30. Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Carol Allan, MD 31. Date filed (Month, Day, Year) Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 27. Physician/ Blake 6:44 AM Jane ,2011 Marv March Medical 4a. Facility Name (if not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery <u>Bethesda</u> Suburban Hospital Center If Under 24 Hrs 9. Birthplace (State or Foreign Age (In yrs. last birthday) **Funeral** 1 M 2 A Min Months Days Hours 1938 Washington, 73 577-52-8843 Director April Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location within 72 hours after death with the Maryland or than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at Director 1 ☐ Yes 2 💆 No Rockville Montgomery Maryland 10g. Citizen of What Country? U.S.A.10f. Zip Code 10e. Street and Number Funeral 20852 4620 Randolph Road 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.)

1 ☐ Yes 2 ☐ No Specify: 14. Race - American Indian. 12. Was Decedent Ever in U.S. Black, White, etc. 1 Never Married 2 Married ò 1 ☐ Yes 2 X No If Yes, Give Year or Dates. Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced Completed Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working Il Hygiene. life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Food Service Waitress t. Page 1 and 2 should be filed with truent of Health and Mental Hygier rtant: If item 27 is marked other t ijury or other traumatic event, th Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) P Daisy Embrey <u>Edward L. Dempsev</u> 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4620 Randolph Road, Rockville, Maryland 20852 Phillip E. Blake - Husband 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) permit. Page Department of Important: If any injury or Oakton, Virginia 4 ☐ Donation 5 ☐ Other (Specify) Flint Hill Cemetery Apr.1,2011 Gary Downer 22. Name and Address of Facility Money & King Funeral home, Inc. 21. Sign de of Funeral Service Licens Virginia 22180 171 W. Maple Ave., Vienna, CCO 508 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Onset and Death Immediate Cause (Final Pancreatic Cancer Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Be Completed by Physician/Medical Examiner Due to (or as a consequence of) use as the burial-transi Cause Disease or liniury that initiated events resulting in death) Last Due to (or as a consequence of) been signed by the attending physician IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 X No jo Month Day Year should be detached 1 ☐ Yes 2 y 9 ☐ Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Records, 24b. Were autopsy findings available prior to completion of cause of 24a. Was an this certificate has autopsy death? To the Hospital or Attending Physician: The 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital completed filled in by the funeral director. 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital 2 💢 No 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: To 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred within 24 hours after death. To the Funeral Director: After 1 X Natural (Month, Day, Year) work? 1 ☐ Yes 2 ☐ No 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number determined City or Town, State) Medical 29a. Certifier 1💢 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and 29c. License numbe 29d. Date signed (Manth, Day, Year) 30. Name and address of per son who completed cause of death (Item 23a) (Type, Print) 8600 Old Georgetown Rd. Bethesda, Maryland 20814

Registrar DHMH 17 Rev 7/2009

State

ata 31. Date filed (Month, Day, Year)

SARA SARA

BLAME

32 Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ inaton Medical ot institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kaven 1 Year If Under 24 Hrs. 8. Date of Birth Jast birthday) **Funeral** Months Days Hours Min Director 110 Usual Residence of Deceden "natural", or items 23a or 28a-f show edical Examiner must be notified at 10a. State 10b. County 10d. Inside City Limits 10c. City, Town or Location filed within 72 hours after death with the Maryland Director 1 XYes 2 □ No more 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 11. Marital Status Race - American Indian ed Forces? Yes 2 \(\square\) No Black, White, etc þ 1 Never Married Married Yes 2 Yes, Give Year or Dates Baltimore, Maryland 21215-0036 1 Yes No Specify Completed 3 Divorced 4 Divorced Page 1 and 2 should be filed within 72 hour ment of Health and Mental Hygiene. ant: If item 27 is marked other than "natuury or other traumatic event, the Medical ury or other traumatic event, the Medical 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4 or 5+) Be Father's Name (First, Middle, Last) 2 Informant's Name/Relationship (Type, 19b. Mailing Address (St Department of Health ar Important: If item 27 is any injury or other trau Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other place, 4 Donation 5 Other (Specify) Signatur of Funeral Se Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dving such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Pnysician/ ementia disease or condition Medical resulting in death) Examiner Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events attending physician and for use as the burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed Exam Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy5 ☐ Other (specify) ____ in the past 12 months? Month Day Year 4 ☐ Pregnant at time of death 9 ☐ Unknown 2 No the page 2 should be detached 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has autopsy performed 2 🗌 No Yes Yes 25. Was case referred to medical completed filled in by the funeral director, 26. Place of Death (Check only one) Be Hospital 2 **X** No Other: 1 Yes မ 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: Natural injury 5 Pending work after death. 1 Yes 2 No Investigation 6 Could not be Accident Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 24 hours Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated within 2 To the I nly or 29d. Date signed (Month, Day, Year) completed cause of death (Item 23a) (Type, Print) 3900 1 (Month, Day, Year) State Registrar

ORIGINAL

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month April Physician/ 2011 2:30pm M Μ. Roland Brown Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Owings Mills Wengate Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 7. Age (In vrs. last birthday) **Funeral** (Month, Day, Year 5-10-192 1 X M 2 □ F Days Director 88 Yrs MD 217-12-5650 Usual Residence of Decedent 28a-f show 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location must be notified at Director 1 Yes 2XX No MD Owings Mills Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code ò Completed by Funeral 23a 21117 United States 145 Wengate Road and 2 should be filed within 72 hours after death v Health and Mental Hygiene. tem 27 is marked other than "natural", or items 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 □ No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 27 is marked other than "natural", or iten traumatic event, the Medical Examiner Black, White, etc. 1 Never Married 2 Married altimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: If Yes, Give Year or Dates 3 Widowed 4 Divorced WW II White 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) 12 years College (1-4 or 5+) American Tote Administrator Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ဂ္ Gill William Brown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3402 Halcyon Road Stevenson, MD 21153 Dorothy Parks (Sister-in-law) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State permit. Page 1 a
Department of H
Important: If ite
any injury or otl 1 Burial 2 X Cremation 3 Removal from State 4-5-2011 4 ☐ Donation 5 ☐ Other (Specify) Carroll Cremation Hampstead, MD Signature of Funeral Service Licensee 22. Name and Address of Facility ELINE FUNERAL HOME 11824 Reisterstown Rd. Reisterstown, MD 21136 J. Wayne Osterling 3a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart knillure. List only one cause on each line. Interval Between Onset and Death Immediate Cause |Final Physician/ Septicoma disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Celly tub Sequentially list conditions. Examiner Due to (or as a consequence of): if any, leading to immediate cause. Enter Underlying attending physician and for use as the burial-transit Sterio VICEA Chrone vonous Cause (Disease or liniury that initiated events Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Chronic edono Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d Date of delivery 3 Fctopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Pregnant at time of death signed by the a P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Atrias fbrilleten To the Hospital or Attending Physician: The law requires 2 🗹 No 3 ☐ Probably 4 ☐ Unknown Records, 1 Yes 24b. Were autopsy findings available 24a. Was an autopsy performed 1 Tyes 25. Was case referred to medical examiner?

1 Yes 2 No Division of Vital 26. Place of Death (Check only one) Other: ည 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 Ø Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: within 24 hours after death.

To the Funeral Director: After to completed filled in by the funera 1 Natural iniury 5 Pending 1 Yes 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year)

\State

DHMH 17 Rev 7/2009

Registrar

GARRY

31. Date filed (Month, Day, Year)

A.

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MATN Street, REISTORS TOWN, MD 2113C

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32. Registrar's Signature

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750

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MANKO

4/5/2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Physician/ Irene Bowling Month 12:40p [™] 2011 Apri Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Carrol1 Transitions Health Care Sykesville Social Security Number 6. Sex If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country)

VV Funeral 7. Age (In vrs. last birthday) 1 □ M 2 🙀 F Days Min. (Month, Day, Y 220-22-8361 84 Director Jan Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Directo MD Sykesville Carroll 1 🗆 Yes 2 🛣 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21784 2 Bethway Drive Apt. 203 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: white 3 XWidowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) 12 College (1-4 or 5+) State of Maryland cafe worker 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Willie Mae Mathis Roy Seal 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1715 Gemini Dr., Sykesville, MD 21784 Dorene Ridgely (daughter) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Crest Lawn Memorial 4-7-11 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of FacilityHaight Funeral Home & Chapel Parge Haight Herbert P.O. Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition resulting in death) Physician/ Medical ras a consequence of):

CPRESSTON Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events resulting in death) Last Examine Due to (or as a consequence of) Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 10 Month Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy eath? Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 1 Yes 2 140 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral of 27. Mai ner Peath 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 5 Pending injury work? 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f, Location (Street and Number or Rural Route Number, 4 Homicide Medical Lecrtifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 0054218 Name and address of person who completed cause of death (Item 23a) (Type, Print) MEXIMINATED MD dun 349 Malcolm Kaneug 31. Date filed (Month, Day, Year) 32. Registrar's Signature APR 0 6 2011 Registrar

P.O. Box 68760

Records,

Division of Vital

Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
Amend 4c per DVR G914 4/18/11 dk
State of Maryland / Department of Health and Mental Hygiene Certificate of Death 191 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Margaret Baum 201 GU7 AM April Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospital Center Mcl Carroll Westminskn tot 3 A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Funeral (Month, Day, Ye 1 □ M 2 👽 Days Hours Year Director 215-01-1067 93 1917 Sept. Usual Residence of Decedent in than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🙀 No MD Carroll Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 110 Terrapin Drive 21784 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 1 ☐ Yes 2 X No If Yes, Give X Year or Dates. 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced Specify: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Domestic Be permit. Page 1 and 2 should be filed Department of Health and Mental Hy Important: If item 27 is marked ott any injury or other traumatic even 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Matthew Donavin Ellen Sellman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mrs. Virginia D. Helsel (Daughter) 12224 Triadelphia Rd., Ellicott City, MD 21042 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Crestlawn Mem. Gardens 4/5/2011 4 ☐ Donation 5 ☐ Other (Specify) Marriottsville, MD 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee MOU764 PO Box 195 Sykesville, MD 21784 23a. Part 1, Enter the disease, or complication, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Respiratory Faciliare hysician/ Right hoverlibe Preumonia, disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Chronic Obstructus Pulmoney Disense Equantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to (or as a consequence of): physician and the burial-transit Hypernatrema that initiated events Due to (or as a consequence of) resulting in death) Last Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 3 Ectopic pregnancy

4 Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Dav 1 ☐ Yes ∠y 9 ☐ Unknown a Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Altered mental status, Panene To the Hospital or Attending Physician: The law requires t within 24 hours after death.

To the Funeral Director. After this certificate has been sign completed filled in by the funeral director, page 2 should be tlyper | n1 | Yes 2 | No 3 X Probably 4 | Unknown Chronic anemia 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?
☐ Yes 2 2 N 1 Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ျှ Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural
2 Accident
3 Suicide
4 Homicide 5 Pending 1 Yes 2 No Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 1 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
| Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 29b. Signature and title of certifie D0069086 April 2, 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHINTU SHARMA Carnoll Hightal Center Westminster MD 31. Date filed (Month, Day, Year)

DHMH 17 Rev 7/2009

State Registrar

0 6 2011

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

32. Registrar's Signature

11-02536 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Garrett Edward Balog State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Da April 2, 2011 1802 hrs **Medical Examiner** Garrett E. Balog 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Middle River **Baltimore County** 35 Oak Grove Drive Apt A 5. Social Security Number If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min. 10/09/1971 Country) MD. Director 212-88-7207 39 1 M 2 F Usual Residence of Decedent 10d. Inside City Limits in 10c. City, Town or Location 10a State 10b. County Md Baltimore 1 Yes 2 No Show Pages 1 and 2 should be filed within 72 hours after death with the Maryland not of Health and Mental Hygiene.

In: If item 27 is marked other than "natural", or items 23a or 28a-f sho nr other traumatic event, the Medical Examiner must be maiffed at example. 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code Pelham Ave 21213 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14 Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married Yes White 3 Widowed 4 Divorced f Yes, Give Year or Dates: 1 Yes 2 No specify: Specify: ۵ 15. Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) **Baltimore, MD 21215-0036** 11 Yrs Hardwood Floor Instalation Hardwood Flooring 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Gary E. Balog Doris Lea Jones Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ٥ 19a. Informant's Name/Relationship (Type, Print) Doris Lea Neidhardt(Mother) 6490 Pamadeva Rd. Hanover, Pa. 17331. 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State permit. Pages
Department o
Important: 1
injury or oth All County Cremation 04/04/2011 | Sykesville, Md. 4 Donation 5 Other Specify. 22. Name and Address of Facility Haight Funeral Home & Chapel 21. Signature of Funeral Service Licensee P.O. Box 195 Sykesville, Md. 21784. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Atherosclerotic Cardiovascular Disease Complicated Approximate Interval Between Onset and **Physician** Mindical by Methadone Intoxication Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of). Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical 23a,pt.II,27,28a-f per me g914 4-22-11 vt **X** UNPENDED **AMENDED** attending physician or use as the burial Box 68760, 23d. Date of delivery IE EEMALE 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the 1 Live birth 3 Ectopic pregnancy Day 2 Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) signed by the atte 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ≥ 1 Yes 2 No 3 Probably 4 Unknown Diabetes Mellitus Completed this certificate has been s I director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of autopsy death? performed? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 Other Nursing Home 5 Residence 6 🗸 Other: Scene 1 Yes After t 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of Injury 8c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 1 Yes 2 X No I Director: ed in by the f 5 Pending after death. fd 4-2-11 subject took drug fd 5:55pm 2 X Accident Investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 35 Oak Grove Dr. Apt. A. Middle River, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc. 6 Could not be Suicide found in dwelling determined (Specify)

Hospital or Attending Physician: An 24 hous.

DOME

Registra

Homicide 29a. Certifier 1

29b. Signature and title

30. Name and addre

Mary G. Ripple MD.

31. Date filed (Month, Day, Year) 2. Registrar's Signature State

and manner stated

of person who completed cause of death (Item 23a)

Deputy Chief Medical Examiner

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Wedical Examiner:On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c, License number

O.C.M.E

111 Penn Street, Baltimore, MD 21201

29d. Date signed (Month, Day, Year)

April 3, 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ ADri 5:15 P M arnes Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Haven Nursing Baltimore ttome atonsvi Social Security Number If Under 1 Year | If Under 24 Hrs. 8 Date of Birth Birthplace (State or Foreign Country) Funeral last birthday) 1 M 2 Months Director or 28a-f show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown injury or other traumatic event, the Medical Examiner must be notified at ange. 10a. State 10b. County Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits MD 1 🗌 Yes 2 🖊 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14 Race - American Indian Armed Forces Black, White, etc. If Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: 3 Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) day (0-12) College (1-4 or 5+) 5Surter To Be Eather's Name (First, Middle, Last) 18, Mother's Name (First, Middle, Maiden Surname) nnie 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route, Number, City or Town, State, Zip Code) DR. ihir lei Chapelgate Udenton, mo aranadayahter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Kandallstown 5 Other (Specify) 21. Signature of Funeral Service Licen 22. Name and Address of Facility HOM Prochilfon toss 23a. P. F. Epler the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, in heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury that initiated events Certificate: To Be Completed by Physician/Medical Examiner Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year 1 Yes 2 L 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗷 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has formpleted filled in by the funeral director, page 2 s autopsy performed 2 2 N 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at work? 1 ☐ Yes 2 ☐ No 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 1 Natural injury 5 Pending Accident Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) HYSICIAN Name and address of person who completed cause of death (Item 23a) (Type, Print) REETINDER BALTI MORE MO 31. Date filed (Month, Day, Year) State Begistrar's Signature Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 03 JAMES BROWN 03-59 AM 20 l Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Upper Chesapeake Medical Center Belair Harford 8. Date of Birth (Month, Day, Year) Mar. 10.1 7. Age (In yrs. last birthday)

57 Yrs. If Under 1 Year If Under 24 Hrs. **Funeral** 9. Birthplace (State or Foreign 1 ☑ M 2 □ F Days 215-60-3741 Months Min. Hours Country) Director Usual Residence of Decedent 28a-f show notified at 10a State 10b County 10c. City, Town or Location Director 10d. Inside City Limits MD Harford Edgewood Baltimore 1 X Yes 2 No 10e, Street and Number ក 10f. Zip Code "natural", or items 23a or idical Examiner must be r 10g. Citizen of What Country? Funeral 1427 Charlestown Drive 21040 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo If Yes, Give Year or Dates. þ 1 ☐ Yes 2 🔀 No Specify: SpecifBlack 3 Wildowed 4 Divorced Completed the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry
on Secour Hospital (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Materials Coordinator llth other Be 17. Father's Name (First, Middle, Last) t. Page 1 and 2 should be filed thent of Health and Mental H rtant: If item 27 is marked ot vjury or other traumatic ever 18. Mother's Name (First, Middle, Maiden Surname) ည 000 Joe Brown Nora Griffin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1427 Charlestown Dr, Edgewood, Md. 21040Regina Brown (wife Department of Health
Important: If item 27
any injury or other t Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from St 4 ☐ Departion 5 ☐ Other (Specify) King Mem.Pk Apr. 7, 2011 Balto, Md. gna ure of Funeral Service Licensee Calwin Adess ්රිප්අuggs Funeral Home Preston St. Balto,Md. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ ACUTE MYO CARDIAL INFARCTION disease or condition Medical resulting in death) Due to (or as a consequence of): **Examiner** ATHERO SCLEROTIC CARDIO VASCULAR Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Examine Due to (or as a consequence of) attending physician and for use as the burial-transit DIMBETES MELLITUS Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Day Year 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC RENAL FAILURE Records, 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown Completed VOSCULAR DISEASE PERIPHERAL 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an FOOT performed certificate ULCER DIABETIC 1 Yes 2 No Yes 2 1 No Sames Division of Vital the Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 2 No Other: မ 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) Director: After this 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28c. Injury at 28d. Describe how injury occurred Natural 5 Pending iniury work?
1 Yes 2 No ☐ Accident ☐ Suicide Investigation Brown, 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, ☐ Homicide within 24 hours a Medical 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 2011 D021207 03 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5 MIDCREST CT, BALTIMORE, OFD 21286 VELLA-CAMILLERI 31. Date filed (Month, Day, Year) 32 Registrar's Signature State APR-06 Registrar

DHMH 17 Rev 7/2009

M800317474

State Registrar

Baltimore, Maryland 21215-0036

Box 68760

P.O.

Records,

Division of Vital

DHMH 17 Rev 7/2009

30. Name and add

31. Date filed (Month, Day, Year)

Satgam, Shah, M.D., 1500 Forest Glen Road, Silver Spring, MD 20910

ess of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

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			100		

		1- For State Registrar		rtificate of	Death			eg. No.		
Physicia edical Exami		Decedent's Name (First, Middle,	Charlie	G. E	ryant		2. Date of Dea Month March 31	Day Year	3. Time of Death 0056 hrs	
		4a. Facility Name (if not institution, Route 210 at Palmer Ro	•	4	b. City, Town, or L Fort Washing		h	4c. County of Prince G		
Funeral Director		577-96-9639	7. Age (In yrs. 18 11X M 2 F		If Under 1 Year Months Days	If Under 24Hr Hours Min	_	th(MM/DD/YYYY) 3/1962	9. Birthplace (State or Foreign Country) VA	
ow any		Usual Residence of Decedent 10a. State 10b. County MD Prince	George's	Town or Location	on Temple	Hills			10d. Inside City Limits 1 XYes 2 No	
Maryland r 28s-f show	Director	10e. Street and Number	ole Hill Road		10f. Zip Code 207		1	0g. Citizen of Wha		
th with the tems 23a o	Funeral D	11. Marital Status 1 X Never Married 2 Marri	12. Was Decedent Ever in U. Armed Forces?		Decedent of Hispes, specify Cuban,	anic Origin? (S		- 14. Race - White,	- American Indian, Black,	
's after dez Iral'', or i	ā		1 Yes 2 No ced If Yes, Give Year or Dates:		Yes 2X No		work done	Specify:	White	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumante eveet, the Medical Examiner must be softfled at soce.	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	during mo	st of working life. I ywall I	nstal:	tired) Ler	Cons	struction	
1215-0036 I be filed within 7 ental Hygiene. arked other than veot, the Medica	Be		hen Bryant Jr			Katl	nleen	Maiden Surname) Daly		
MD 21 od 2 should i lith and Mer m 27 is mar	բ		nt Jr./Father	6807	Temple	Hill 1	Rd., Te	emple H		
Baltimore, bernit. Pages I an Department of Hea important. If ite		20a. Method of Disposition 1 Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State	crematory or oth	tion (Name of ceme er place) Ney crem.		Date 7/2011	Woodbi:	City or Town, State	
Balti permit. Departm Importa		21. Signature of Funeral Service Li	Conson Dorota Marsha		PO Bo	and Cr x 1413	. Balt		MD 21203	
Physician /Medical Examiner		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease a. Multiple Injuries								
		or condition resulting in death) Sequentially list conditions,	Due to (or as a consequence of b.	·	_					
	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of c. Due to (or as a consequence of							
760, Teate be executed I physician and the burial - transit		UNPENDED Cast	d. AMENDED							
8760, ificate be up physicials the buria		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr		al death 3	Ectopic prean	ancv	23d. Date of o	delivery Day Year	
Box 687 e death certific the attending led for use as the	Physicia	past 12 months? 1 Yes 2 No 9 Unkno	4 Pregnant at time of dea	ath	er (Specify)				,	
, P.O. ires that the signed by t	Ď	Part II. Other significant condition	ns contributing to death but not re	esulting in the ur	nderlying cause giv	en in Part I.			oute to the cause of death? Probably 4 Unknown	
cords law requi	Completed						24a. Was autop perfo	pr med? de	/ere autopsy findings available for to completion of cause of eath? ✓ Yes 2 No	
tal Recidence The certificate ector, page	Be C	25. Was case referred to medical examiner?				of Death (Check	only one)			
Physic Physic or this	2	1 ✓ Yes 2 No 27. Manner of Death	Hospital: 1 Inpatient 2 2	ER/Outpatient 28b. Time of In				Residence 6		
Division of Vital tall or Atteodiog Physiciae: Is after death. al Director: After this certiled in by the funeral director.	ation:	1 Natural 5 Pending 2 ✓ Accident Investig	g Mar 31, 2011 aar)	0013 hrs	1 Ye	s 2 🗸 No	Driver of ve	hicle involved	in collision	
Division Bospital or Atteo 4 hours after deatt Fuecral Director: ctely filled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determi			, factory, office bu	Ilding, etc.	or Town, S	tate)	r or Rural Route Number, City ort Washington, MD	
29a. Certifier (Check only one) 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and manner as stated one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause (s) and due to the cause (s) and due to the cause (s) and due to the cause (s) and									e to the cause(s)	
	Σ	29b. Signature and title of certifier	- Pall L		29c. License O.C.M			29d. Date signed March 31, 2	d (Month, Day, Year)	
v		30. Name and address of person with Patricia Aronica-Pollak I			111 Penn Stre	eet, Baltimo	re, MD 2120	1		
St Regist	ate		32. Dustrar's Signatu	A THE PARTY OF THE	4)		· ·			
DHMH 17 Rev 1/20		APK-() b	DOME 2011	ORIGINAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 3 Year 4:00 XIhe 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b, City, Town, or Location of Death 4c. County of Death Moravia tark Dr. Himore Social Security Number 7. Age (In vrs. last birthday) If Under 24 Hrs. 8. Date of Birth (Month, Day, \$ - 2.8 - Birthplace (State or Foreign Country) **Funeral** 219-40-371 Months Days Min Hours **Director** Usual Residence of Decedent or 28a-f show e notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No Himore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21206 US A 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Was Decedent - Armed Forces?

1 Yes 2 No Black, White, etc. 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 Yes 2 No If Yes, Give Year or Dates Black 3 Divorced Completed Specify: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College, (1-4 or 5+) actory orker Be Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ၉ Long 19a. Informant's Name/Relationship voe. Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Plainf 20a. Method of Disposition 20b. Place of Disposition (Name of Burial 2 Cremation 3 Removal from State cemetery, crematory or other -2011 ansdowne, MA 21. Signature of Funeral Service Licensee 22. Name and Address of Facility March 1101 EI Nouth Baltimore 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph_sician/ tension disease or condition resulting in death) Medical Due to r as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examiner Due to (or as a consequence of). After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transit Cause (Disease or linjury the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?

1 Yes 2 No Pregnant at time of death Month 1 Yes 2-8 Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Completed 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed?

Yes 2 No 1 🗌 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 1 Tes မ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify, Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 \square Pending 24 hours after death.

Funeral Director: A leted filled in by the fu 1 🗌 Yes 2 🗌 No Accident Investigation 3 Suicide 4 Homicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Medical 1 🖳 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. only on 🗹 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the 29b. Signatur and title of certifier 29c. License number Date signed (Month, Day, Year) 2011 completed cause of death (Item 23a) (Type, Print) Name and address of person who 1202 State 6 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician/ 10:49 AM 05 April 2 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Baltimore Washington Medical Center Glen Burnie Anne Arundel 8. Date of Birth (Month, Day, Year) OCt. 05 1926 5. Social Security Number If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Months Days Hours 1 X M 2 - F **Director** 214-22-8025 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important If Item 27 is marked other than "natural" or isomeone any injury or other trainments. 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location Director 1 🗌 Yes 2 🖾 No Pasadena Maryland Anne Arundel 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 8206 Waterford Road 21122 USA Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc 1 Never Married 2 X Married 1 X Yes If Yes, Give þ 2 No White 1 ☐ Yes 2 X No Specify. Specify. 3 Widowed 4 Divorced Completed Year or Dates 16a Decedent's Usual Occupation 15 Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+ Supervisor A.A. Co. Public Works Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ပ Eastridge Ollie Alton Cosner 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Charlotte M. Cosner Waterford Road, Pasadena, MD 21122 8206 (spouse) 20b. Place of Disposition (Name of cemetery, crematory or other place) April 04 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 X Cremation 3 Removal from State Metro Crematory Inc. Baltimore, Maryland 2011 4 Denation 5 Denation f Funeral Se 22. Name and Address of Facility 21. Signa ure Stallings Funeral Home, P.A. 3111 Mountain Road, Pasadena, MD 21122 caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, 23a. Part 1. Enter the dis ase, or complicat Approximate Interval Between shock, or heart failure List only one ca Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) 10/101 Medical Examiner obatru Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of) After this certificate has been signed by the attending physician and funeral director, page 2 should be detached for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy 3 Ectopic pregna 5 Other (specify) in the past 12 months? Month Year Day Pregnant at time of death 2 🗆 No 1 Yes 2 L 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ş 2 No 1 Yes 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performe 1 🗌 Yes 2 🗆 No Be 25. Was case referred to predical 26. Place of Death (Check only one) completed filled in by the funeral director, examiner? Other: 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA မ 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death 28a Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: (Month, Day, Year) Natural 5 Pending 1 Yes 2 No death. ☐ Accident ☐ Suicide Investigation 24 hours after dear Funeral Director: 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Hospital Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. within 2 only one) and title of certific License number 29d. Date signed (Month, Day, Year, 1109 234 32. Registrar's Signature 31. Date filed State 6 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Mattnew Coate	S, JI.	1- For State Registrar	tate of Maryland		tment of I			201 Reg. No.	10949		
Physic dical Exam	ian/ iner	Decedent's Name (First, Midd Matthew	Coates, Jr				2. Date of De Month March 5	Day Year	3. Time of Death 1118 hrs		
		4a. Facility Name (if not institution 3300 Flowers Road		-)		City, Town, or Location		4c. County of Dea			
Funeral		5. Social Security Number	6. Sex 7. A	ge (In yrs. las		If Under 1 Year If U		Birth(MM/DD/YYYY) 9. E	Birthplace (State or		
Director		213-44-4797	1 M 2 F	64	Yrs.	Months Days Ho	ours Min. 09/0	5/1946 For	country) Wash. DC		
any		Usual Residence of Decedent 10a. State 10b. County		10c. City, T	own or Location				10d. Inside City Limits		
te Maryland or 28a-f show fied at once,	tor	MD I	PG 	Uppe	r Marlb			10. 000 1110 0	1 X Yes 2 No		
the Mar n or 28a	Director	3300 Flowers A	Road			0f. Zip Code 20774		10g. Citizen of What Co USA	untry?		
ith with tems 23	Funeral	11. Marital Status 1 X Never Married 2 M	12. Was Deceder			ecedent of Hispanic (Origin? (Specify Yes or Noran, Puerto Rican, etc.)		erican Indian, Black,		
ifter dea 11", or it	by Fu		1 Yes 2 vorced If Yes, Give Year or Dates:	X No	1 Y	es 2 X No spec	afy:	Specify: B	lack		
hours a satura	ted b	15. Decedent's Education (Specify only highest grade completed) 15. Decedent's Usual Occupation (Give kind of work of during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+)						16b. Kind of Business/Industry			
1036 rithin 72 ene. rr than '	Completed	12th		3+)	Tras	n Operator		Priv	Private		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygier the Important: If tiem 27 is marked other than injury or other traumatic event, the Medica	Be Co	17. Father's Name (First, Middle Matthew Coate					her's Name (First, Middle ary Savoy	, Maiden Surname)	**************************************		
212 thould be and Meni is mark	To E	19a. Informant's Name/Relations	ship (Type, Print)			ddress (Street and N	lumber or Rural Route No		te, Zip Code)		
e, ML and 2 s Tealth au treum?	- 4	Rosa Taylor -	Companion		ace of Disposition	n (Name of cemetery,	d; Upper Mai	rlboro, MD 20c. Location - City of	20774 or Town, State		
MON Pages 1 nent of F nut: If i		1 X Burial 2 Cremation 4 Donation 5 Other S			ematory or other	emetery	4/6/2011	Suitland	, Maryland		
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygievier Important: If tiem 77 is marked other than "unatural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.		21 Signature of Funeral Service					Freeman Fi Temple Hil				
Physician		23a Fert I. Enter the disease, in failure. List only one cau	complications that caused on each line.	the death. D					Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)			ic Card	lovascu1ar	Disease		Death		
		Sequentially list conditions,	b								
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated									
cuted ind transit	I Exa	events resulting in death) Last	Due to (or as a cons								
60, ate be executed hysician and te burial - transit	Medical	X UNPENDED				per me g9	14 4-22-11				
6876 ertificat ding phy	an/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	I Live billi		2 Fetal	death 3 Ecto	opic pregnancy	23d. Date of delive Month	ry Day Year		
Box 687 e death certifice the attending p	Physician/N	1 Yes 2 No 9 Uni	known 4 Pregnant a 9 Unknown	time or deat	n 5 Other	(Specify)					
cords, P.O. Box 6876 Iaw requires that the death certificat has been signed by the attending ph 2 should be detached for use as the	ē	Part II. Other significant condit	ions contributing to deal	h but not resi	ulting in the und	erlying cause given in		tobacco use contribute t es 2 ✔ No 3 Pro			
Division of Vital Records, P. ral or Attending Physician: The law requires the safter death. al Director: After this certificate has been signe led in by the funeral director, page 2 should be de	Completed						24a. Was	s an 24b. Were a	utopsy findings available completion of cause of		
Reco The law cate has	d mo							ormed? death?			
fital sician: is certifi lirector,	8	25. Was case referred to medica examiner?	Hospital:	ent 2 E	R/Outpatient 3	Other	th (Check only one) Nursing Home 5	Residence 6 ✔ Oth	er: Scene		
Division of Vital Recipital or Attending Physician: The Iours after death. eral Director: After this certificate if filled in by the funeral director, page	<u>ان</u>	1 Yes 2 No 27. Manner of Death 1 X Natural 5 Pens	28a. Date of Inji (Month, Day,)	ıry 2	8b. Time of Inju	y 28c. Injury at Wo	ork? 28d. Describe	how injury occurred	31. 030110		
isior Attend er death. rector: by the	icatio	2 Accident Inves	stigation 290 Place of Ir	niury - At hom	e. farm. street. f	1Yes 2[actory, office building,		(Street and Number or F	ural Route Number City		
Div pital or cours after filled in	Certification:	4 Homicide deter	d not be rmined (Specify)		, , , , , , , , , , , , , , , , , , , ,		or Town,				
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed writin 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	29a. Certifier (Check only one) 2 Medical Exa	hysician: To the best of m miner:On the basis of exa	y knowledge, mination and	, death occurred /or investigation	at the time, date and in my opinion, death	place, and due to the cau occurred at the time, date	use(s) and manner as sta e and place, and due to t	ted. he cause(s)		
T _o	Me	29b. Signature and title of certifie	and manner stated.			29c. License numb	er	29d. Date signed (M	onth, Day, Year)		
100		30. Name and address of person	melfrell	leath (Item 00	39)	O.C.M.E.		March 6, 2011			
pand		Margarita Korell MD.	•		*	altimore Street, I	Baltimore, MD 212	23			
St Regis	_	31. Date filed (Month, Day, Year) APR 0 6 201	32. Registra	r's Signature	barks						

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		- For State tegistrar		or many are			ate of				Reg. I		10000
Physiciar	n/	Decedent's Name (First, M	liddle,La	st)	-					2. Date of D	eath		3. Time of Death
Medical Examin		Franklin	Teri	cell Ca	udill					Month March 2	28, 20	y Year 1 11	2249 hrs
	•	4a. Facility Name (if not instit	tution, gi	ve street and numb	er)		4k	. City, Town,		of Death		4c. County of Dear	
		300 Taplow Road						Baltimore				N/	
Funeral Director		5. Social Security Number 235-78-3326		7. M 2 F	Age (In yrs. la:	st birt	hday) Yrs.	If Under 1 Y Months D	ays Hours			1945 9. Bi	
b	- 1-	Usual Residence of Deceden 10a. State 10b. Cour			10c. City,	Cours	or Logotic						10d. Inside City Limits
and f show any	-	Maryland	N/A				more						1 X Yes 2 No
Maryl 28a-	Director	I0e. Street and Number						10f. Zip Code)		10g. (Citizen of What Cou	intry?
3a or		300 Taplow Ro	oad					2	1212			U.S.A.	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. In profram: If item 71 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at once.	a l	1. Marital Status 1 Never Married 2 X		1 TZ Yes	95?					gin? (Specify Yes or n, Puerto Rican, etc.)	No-	14. Race - Ame White, etc.	rican Indian, Black,
after after iner:	ځL	3 Widowed 4	Divorce	If Yes, Give Year 1	968-1972		1 1	es 2X	No specify:	•		Specify: W	hite
72 hours	Completed by	15, Decedent's Education (S Elementary/Secondary (0-		College (1-4				Usual Occup t of working l		kind of work done use retired)	16	b. Kind of Business	/Industry
O36	림			5+ year	rs		At	torney	7			Law	
Hygie of the N		7. Father's Name (First, Mid-	dle, Last)						r's Name (First, Middle	e, Maid		·
be fi	8	Carrel		Caud	i11				Elea	nor Anne		Campb	
thould Manuficer		9a. Informant's Name/Relation				19b	. Mailing A	Address (Str		nber or Rural Route N		•	e, Zip Code)
nd 2 salth a salth a raum		Michela S. Co	audi	11 (w)	ife)	3	00 Ta	plow F	Road	Baltimore,			21212
S i a of He of He tr		1 Burial 2 X Crema	tion 3	Removal from			ory or othe		cemetery,	Date	20	c. Location - City o	r Iown, State
Page Page ment tant:		4 Donation 5 Other			Gree	en	Moun	t Crem	atory	4-4-11	Ва	altimore,	Maryland
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene. Important: If item 27 is marked other than injury or other traumatic event, the Medical		1. Signature of Funeral Serv	Fu	rouse			22. Na Mi t	ne and Addre Chell- 00 Yor	wiede Wiede k Roa	y feld Funer d Baltimo ardiac or respiratory a	al ore	Home, Inc	i 21212
Physician		3a. Part. Enter the disease, failure. List only one caummediate Cause (Final disease)	use on e	olications that caus ach line. Atheroscleroti					ig, such as c	ardiac or respiratory	arrest,	shock, or heart	Approximate Interval Between Onset and Death
źxaminer		or condition resulting in death		Due to (or as a co									
		Sequentially list conditions,	b.										
		fany, leading to immediate auto Enter Underlying Cau	ee .	Due to (or as a co	nsequence of):								
red nsit	Xar E	Disease or injury that initiate events resulting in death) Las	d C.	Due to (or as a cor	nsequence of):								
xecuted n and l - transit			d.										
8 4 6	ان	LINDENDED	I IX	AMENDED									

To the Hospital or Attending Physician: The law requires that the death certificate be e within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physicial completely filled in by the funeral director, page 2 should be detached for use as the burial Division of Vital Records, P.O. Box 68760,

Physician/Medi Completed by Be Medical Certification: To

#las noted, perME, G914, 4/6/2011, WS IF FEMALE 23c. If yes, outcome of pregnancy Was decedent pregnant in the Live birth 2 Fetal death 3 Ectopic pregnancy past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. **Epilepsy** 25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 1 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 1 V Natural 5 Pending 1 Yes 2 No 2 Accident Investigation

Yes 2 ✔ No 26.Place of Death (Check only one)

O.C.M.E.

24b. Were autopsy findings available prior to completion of cause of death?

Day

Year

Other Nursing Home 5 Residence 6 🗹 Other: Scene 28d. Describe how injury occurred

24a. Was an

or Town, State)

autopsy performed?

23d. Date of delivery

23e. Did tobacco use contribute to the cause of death?

28f. Location (Street and Number or Rural Route Number, City

March 29, 2011

1 Yes 2 No 3 Probably 4 ✔ Unknown

Month

29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occur	rred at the time, date and place, and due to the caus	e(s) and manner as stated.
one) 2 Medical Examiner: On the basis of examination and/or investigat and manner stated.	tion, in my opinion, death occurred at the time, date	and place, and due to the cause(s)
29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)

28e. Place of Injury - At home, farm, street, factory, office building, etc.

30. Name and address of person who completed cause of death (Item 23a)

Could not be

111 Penn Street, Baltimore, MD 21201 Zabiullah Ali, M.D. Assistant Medical Examiner

31. Date filed (Month, Day, Year) State Registrar

3

Suicide

Homicide

6

32. Registrar's Signature

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene Harvey Carney 1- For State Certificate of Death Reg. No Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ 1945 hrs Medical Examiner tarve March 28, 2011 arne 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 3005 The Alameda **Baltimore** If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year **Funeral** 6. Sex Days Months Hours Min. Director 1 V M 2 F Country) Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location 1 Yes 2 No Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. Director 10f. Zip Code 10g. Citizen of What Country 10e, Street and Number Funeral 11. Marital Status Unk 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Armed Forces? Never Married 2 Married Yes 2 No Yes 2 No specify: If Yes. Give Yeer <u>چ</u> 16a. Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b, Kind of Business/Indus Completed during most of working life. DO NOT use retired) UNK College (1-4 or 5+) MD 21215-0036 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be 19a. Informant's Name/Relationship (Type, Print) (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health and M

If item 27 is m. alen, NG Winston 20b. Place of Disposition (Name of cemetery. Date 20c. Location - City or Town, State 20a Method of Disposition crematory or other place) 2 Cremation 712011 altimore Other 22. Name and Address of Facility gwell uneral ibertu Balto Heighta 2120 Approximate Interval art . Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as a Physician failure. List only one cause on each line Retween Onset and √Medical Death a. Atherosclerotic Cardiovascular Disease Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate Due to (or as a consequence of): Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Sa UNPENDED AMENDED the attending physician ned for use as the burial Hospital or Attending Physician: The law requires that the death certificate be Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery IF FEMALE Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Day Year 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown P.O. 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 ✓ Yes 2 No 3 Probably 4 Unknown Division of Vital Records, Completed this certificate has been a director, page 2 should 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed . death? Yes 2 No 1 🗸 Yes 2 No 26.Place of Death (Check only one) 25. Was case referred to medical Other Nursing Home 5 Residence 6 Other: Scene 1 Inpatient ER/Outpatient 3 DOA 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work 28d. Describe how injury occurred ✓ Natural 5 Pending 1 Yes 2 No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 3 6 Could not be Suicide Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check only). 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) March 29, 2011 O.C.M.E. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 32. Registrae's Signature State Tore de Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April 5, 2011 Lewis Coghill 8:10 AM Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Sandy Spring Brooke Grove Rehab & Nursing Center Montgomery 5. Social Security Number If Under 1 Year If Under 24 Hrs. 7. Age (In vrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Year 1916 1 □ M 2 🗓 F Days Hours Min. Nov. 19, Director 225-10-0444 94 Virginia Usual Residence of Decedent shov ıral", or items 23a or 28a-f sho Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 🗌 Yes 2 🛛 No Maryland Montgomery Sandy Spring 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 18131 Slade School Road 20860 U.S.A. Was Deced Armed Forces? 11 Marital Status Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, ģ 1 Never Married 2 Married Yes Yes, Giv Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: White Completed 3 Nidowed 4 Divorced Year or Dates or other traumatic event, the Medical 15. Decedent's Education 16a Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျှ William Grover Lewis Nellie Ward 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) of Health of item 27 i Lewis Ward Coghill (Son) 16920 Old Colony Way, Rockville, MD 20853 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date Department of H Important: If ite any injury or ot Morratice out Bapth Islace) 1 X Buriar 2 Cremation 3 Removal from State 4-11-11 4 Donation 5 Other (Specify) Cemetery Kilmarnock, VA 22. Name and Address of Facility Currie Funeral P.O. Box 1275, 21. Signature of Fu neral Service Licen Home, LLC Kilmarnock, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Physician/ Arteriosclerotic Cardiovascular Disease disease or condition Mean. Examiner Medical resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months?

1 Yes 2 No After this certificate has been signed by the atter funeral director, page 2 should be detached for a Year Dav Pregnant at time of death g 🗌 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Chronic Renal Insufficiency Division of Vital Records, 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 X No 2 🗌 No 1 Tes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 2 🗓 No Other: 4 X Nursing Home 5 Residence 6 Other (Specify) Hospital 1 🗌 Yes မ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred or Attending (Month, Day, Year) 1 X Natural 5 Pending 24 hours after death. Funeral Director: A Accident 1 Yes 2 No Investigation filled in by the Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Hospital Medical 29a. Certifier 🖾 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Gertifying Nurse Profitioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
3 Certifying Nurse Profitioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the within 2 29b. Signature and tyle of certifier 29c. License number D08381 April 5, 2011 of person who c mpleted cause of death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 7/2009

State

P.O. Box 68760

32. Registrar's Signature

Avrunin, M.D.

Benjamin 31. Date filed (Month. 18111 Prince Philip Dr. #209 Olney, MD 20832

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Year Christine U. Cardillo 6:30 a April 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death 4301 Brittany Drive Ellicott City Howard 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Country)
Prussia '. Age (In yrs. last birthday) 8. Date of Birth **Funeral** 104-28-8935 74 0871571936 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at Director 10d. Inside City Limits 28a-f MD Howard 1 Yes 2 XNo Ellicott City 10e, Street and Number 10g. Citizen of What Country? ms 23a or must be r Funeral 4301 Brittany Drive 21043 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married ò Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: "natural", 3 Midowed 4 ☐ Divorced Specify: White Completed Year or Dates the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) nt of Health and Mental Hygiene.

If item 27 is marked other than or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Book Keeper Mortgage Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Stephan Rutner Maria Krause 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: If item 27 is any injury or other tra once. Catherine T. McCarthy - dau. 4301 Brittany Drive Ellicott City, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State cemetery, crematory or other placel 4 Donation 5 Other (Specify) Ardent Crematory 04/09/2011 Hanover, MD 22. Name and Address of Facility Harry H. Witzke's Family F.H.Inc. 21. Signature of Funeral Service Licensee Shem 4112 Old Columbia Pike Ellicott City, MD 21043 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only one cause interval Between Immediate Cause (Final Physician/ LOVOS disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner orowa Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician be detached for use as the burial Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 mont Month Day 1 Yes 2 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Records, Completed 1 Tes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available has prior to completion of cause of death?

1 □ Yes 2 □ No ____ autopsy perform Yes 2 Division of Vital Hospital or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? မှ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify, within 24 hours after death.

To the Funeral Director: After thi completed filled in by the funeral or 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b, Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending work? 1 ☐ Yes 2 ☐ No 2 Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. determined Medical 1. Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who co pleted cause of death (Item 23a) (Type, Print) Ellicotta - fider RD 2850 North 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - For State Registrar Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April Elsie Leone Corbin 2 201 Par 7:28 ам Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Carroll Hospice Dove House Westminster Carroll Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Months Days Min 1 M 2 TF Hours March, 1928 west Virginia Director 216-24-6209 83 Yrs Usual Residence of Decedent or 28a-f show notified at and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f sho 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits Director Maryland Carroll Manchester 1 🗆 Yes 2 🗓 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ems 23a or Funeral 3306 Meadowview Drive 21102 U.S.A. items 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, "natural", or iter Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 Married ģ Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☐ No Specify. Completed 3 X Widowed 4 Divorced Specify: White the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Communications Supervisor of Hospital event, Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ္ Roy Smith Mildred Winnie Bourne or other traumatic 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mildred J. Corbin daughter 3306 Meadowview Dr. Manchester, MD. 21102 item 20b. Place of Disposition (Name of permit. Page 1 a Department of H Important: If ite any injury or ot 20c. Location - City or Town, State cemetery, crematory or other partil 1 XBurial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Evergreen Mem. Gardens Finksburg, 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Eckhardt Funeral Chapel P.A Had Illa 3296 Charmil Dr. Manchester, MD. 21102 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Ph_sician/ earl angestive disease or condition Medical resulting in death) Due to (or as a presequence of) Examiner 0 Sequentially list conditions, Examine cause. Enter Underlying nellmoma attending physician and for use as the burial-transi Cause (Disease or iinjury that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregna 5 ☐ Other (specify) in the past 12 months? Ectopic pregnancy Month Day signed by the al Id be detached fo Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? <u>چ</u> 2 No 3 Probably 4 Honknown Completed 24 hours after death.

Funeral Director. After this certificate has been as be 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autope performer death? ☐ Yes 1 Yes 2 No funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Detrier (Specify) DNF 1 Tes 2 No ၉ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of injury (Month, Day, Year) 27. Manner eath Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred HOUSE 1 atural 5 Pending 1 🗌 Yes 2 🗌 No ☐ Accident ☐ Suicide Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 🔽 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2. only one) 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and 29c. License number D - 0054218 address of person who completed cause of death (Item 23a) (Type, Print) Malcolm dure, West minuty MD 21157

State Registrar 32. Registra 's Signa

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 209ª1 Warren Louis Dunnavant 9:40 Рм Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 9. Birthplace (State or Foreign Min. 076-44-5261 Hours NEW YORK **Director** Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location notified at 10d. Inside City Limits Director FREDERICK 28a-f MO FREDERICK 1-Yes 2 No 0 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ral", or items 23a or Examiner must be r Funeral 6tRMIND DRIVE 21701 USA death 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. þ 1 Never Married 2 Married 2 No 1 Yes 2 Page 1 and 2 should be filed within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Z No Specify: "natural" Completed 3 Widowed 4 Divorced Specify: BLACK Year or Dates of Health and Mental Hygiene. item 27 is marked other than "natur other traumatic event, the Medical. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) **Z YR S** SELF EMPLOYED OMPUTER TECHICIAN Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည DUNNAVANT WILLIAM SEAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) WARREN L. DUNNAVANT 1683 8TH AVE BROOKLYN NEW 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Department of Important; If it any injury or o 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place, 4 ☐ Donation 5 ☐ Other (Specify) April 8, 2011 SMITHSBURG MO 22. Name and Address of Facility GARY L. ROWINS FUN, HOME 21. Signature of Funeral Service Licenses oller Muya. SOUTH & PREDERICA MO 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Medical resulting in death) **Examiner** merction Sequentially list conditions, Examine if any leading to in mediat cause. Enter Underlying Cause (Disease or linjury that initiated events resulting in death) Last consequence of that the death certificate be executed and burial-trar Due to (or as a consequence of): physician Physician/Medical Box 68760 the attending properties for use as IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) in the past 12 months? Pregnant at time of death Month Day Year 2 No ed by the detached 9 Unknown P.O. signed by t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by mellitus Division of Vital Records, To the Hospital or Attending Physician: The law requires 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 \(\sum \) Yes \(2 \sum \) No 24a. Was an nas autopsy page performed? Yes 2 N certificate Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital 2 🗆 No Other: မြ 1 🗌 Yes 1 Inpatient 2 FR/Outpatient 3 IDOA After this 4 Nursing Home 5 Residence 6 Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Matural 5 Pending within 24 hours after death.

To the Funeral Director: A completed filled in by the fu 2 Accident
3 Suicide
4 Homicide Accident 1 Yes 2 No Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 29b. Signature and title of certifier 29d. Date signed Month, Day, Year) 39 Name and address of person who completed cause of death (Item 23a) (Type, Print) Date filed Month, Day, Year)

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 2<u>011</u> Physician/ Month James Daniel Medical March 27 0056 A 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Prince Georges' Hospital Cheverly PG 5. Social Security Number 7. Age (In yrs. last birthday) 83 If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 04/13/1927 **Funeral** 9. Birthplace (State or Foreign 1 ★ M 2 □ F Hours 249-40-1121 Director South Carolina Usual Residence of Decedent 10a. State 10b. County and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 10d. Inside City Limits ms 23a or 28a-f s must be notified DC Washington 1 X Yes 2 ☐ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 505 - 34th Street, N.E. 20019 of Health and Mental Hygiene. item 27 is marked other than "natural", or items other traumatic event, the Medical Examiner mu 11. Marital Status 12. Was Decedent Ever in U.S 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Armed Forces? 1 Never Married 2 Married Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates. 50-54 1 Yes 2* No Specify. 3 Divorced Specify: Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) 12th Electrical Technician Federal Government Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ၉ John Henry Daniel Mary Bush 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trauonce. Vivian Daniel - Wife 505 - 34th Street, NE; Washington, DC 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Page 1 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Lincoln Cemetery 04/02/2011 | Brentwood, MD Signatu 22. Name and Address of Facility Freeman Funeral Services 4594 Beech Road; Temple Hills, MD 23a. Part to Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Ph sician/ ATAL disease or condition resulting in death) Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or Exami Hospital or Attending Physician; The law requires that the death certificate be executed physician are the burial-t resulting in death) Last Due to (or as a Physician/Medical Box 68760 attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Live Birth 2 - Fetal death Ectopic pregnancy in the past 12 months? Pregnant at time of death Year Month Dav 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performe page Yes 2 N 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital မ 1 Tes 2 **X**No this 1 Inpatient 2 K ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) Manner of Death 28a. Date of injury (Month, Day, Year) Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 X Natural 5 Pending work? s after death. Accident Investigation the Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 24 hours a Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the I 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) D63688 30. Name and address of person wh completed cause of death (Item 23a) (Type, Print) GRIFFIN DAVIS 3001 31. Date filed (Month, Day, Year, State 32. Registrar's Signature 6 Registrar

DHMH 17 Rev 7/2009

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ April Day 2011 7:05 P M William Joseph Donahue, Jr Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Silver Spring Renaissance Gardens Montgomery Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Funeral 8. Date of Birth 9. Birthplace (State or Foreign 1**5**€ M 2 🗆 F Months Days Hours Min Mary Land Director 218-12-5335 88 Usual Residence of Decedent 28a-f shov 10a. State 10b. County 10c. City, Town or Location Examiner must be notified at 10d. Inside City Limits Director MD Montgomery Silver Spring 1 ☐ Yes 2 1 No 10f. Zip Code ö 10e. Street and Number 10g. Citizen of What Country? or items 23a Funeral 3128 Gracefield Road HS315 20904 United States Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Agmed Forces?
1 Yes 2 No Black, White, etc. 1 Never Married 2 Married Completed by 72 hours after Baltimore, Maryland 21215-0036 If Yes, Give 1 ☐ Yes 2 No Specify: "natural", 3 № Widowed 4 □ Divorced Specify: Year or Date <u>1.943</u>—46 White the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation Howard County Board of (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Mental Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Education <u>Educator</u> marked other Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ William J. Donahue, Sr. Agnes Stakem it. Page 1 and 2 should of Health and N item 27 is ma 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William J. Donahue, III/son 75 Chautauqua Drive Arnold, Maryland 21012 20a. Method of Disposition 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date ortant: If is injury or o artment of 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place; 4 ☐ Donation 5 ☐ Other (Specify) Ardent Crematory 4/6/2011 Hanover, Maryland per it Depart Impor any in 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Harry H. Witzke's Family F.H. Inc Rahomas 4112 Old Columbia Pike Ellicott City, MD 21043 M00957 Marita 23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Onset and Death Pnysician/ Renal Failure disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Congestive Heart Failure Sequentially list conditions Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): Conary Artery Disease Cause (Disease or iinjury for use as the burial-tran the attending physician and that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live Birth 2 \square Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Pregnant at time of death 5 Other (specify) Month Day Year Yes 2 No g Unknown g Unknown been signed by t should be detack Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Atrial Fibrillation Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛂 Unknown History of Myocardial Infarction b/p CABG . Were autopsy findings available prior to completion of cause of death? 24a. Was an After this certificate has page 2 autopsy perform 1 ☐ Yes 2 ☐ No Yes 2X No 25. Was case referred to medical examiner? completed filled in by the funeral director, 26. Place of Death (Check only one) Be 1 ☐ Yes 2 🎦 No Other: Nursing Home 5 - Residence 6 - Other (Specify) Hospital: ပ 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No Accident Investigation after death Director: / 6 Could not be 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital or within 24 hours a To the Funeral D Medical 29a. Certifie X Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 only one) 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) MD

DHMH 17 Rev 7/2009

State

Registrar

31. Date filed (Month, Day, Year)

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32. Registrar's Signature

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			For State		State of M	larylar			Health and	Mental Hy	/giene	2011	10958	
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Baltimore, Maryland 21215-0036	sh is		19a. Informant's Na	me/Relationsh			19b. Mailir	ng Address (Street	and Number or Ru		er, City or			
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DHMH 17 Rev 7/2009

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Baltimore,	permit. Fages I and 2 should be filled within Department of Health and Mental Hygiene. Important: If item 27 is marked other the injury or other traumatic event, the Med		21. Signature of Funeral Service Lic		· · ·	30sep	Address of F	acility r Own	Jr. Fu	neral H	one	PA
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3876	ing phy.	an/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome 1 Live birth	e of pregnanc	y 2 Fetal deatl	h 3Ec	ctopic pregnar	псу	23d. Date of d Month	lelivery Day	Year
Box 687	e usaur certained be executed the attending physician and ed for use as the bunial - transit	Physician/	1 Yes 2 ✓ No 9 Unknow	4 Pregnant at ti 9 Unknown	ime of death	5 Other (Sp	ecify)			1		
P.O.	within 24 hours after death. To the Funeral Director: After this certificate has been signed by the atte completely filled in by the funeral director, page 2 should be detached for u	by P	Part II. Other significant conditions	contributing to death	but not resulti	ing in the underlyir	ng cause given i	in Part I,		bacco use contrib		
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<u> </u>	iw T	¥	29b. Signature and title of certifier	and manner stated.		29	c. License num	nber		29d. Date signed	(Month,	Day, Year)
			mylw	VS			O.C.M.E.			April 1, 2011		
KI			30. Name and address of person who				imara hara	21204				
5 V	91	ate	Ling Li, MD Assistant I 31. Date filed (Month, Day, Year)	Medical Examiner 32. Registrar's	Cignotus		inore, MD 2	Z 1ZUT				
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death March 31, Day 2011 Year Physician/ 10:21 A M Esther Lee Eugene Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Montgomery Takoma Park Washington Adventist Hospital 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign 6. Sex **Funeral** 1 □ M 2 🛚 F OCT. Pgy, Year) 924 Days Hours Louitgiana Months 86 Director 439-04-0864 Usual Residence of Decedent item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits 10b. County within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🛣 No Prince George's Greenbelt 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral U.S.A. 1870 Lakecrest Drive 20770 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⚠ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Never Married 2 Married Completed by Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: **Black** 3 Nidowed 4 Divorced Year or Dates 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) 2 should be filed within 72 h and Mental Hygiene. 7 is marked other than " Elementary/Seconday (0-12) College (1-4 or 5+) Own Home Homemaker 11 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edwage Pierre Williams Leon Williams permit. Page 1 and 2 should be Department of Health and Men Important: If item 27 is marke any injury or other traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4610 Warrington Dr., New Orleans, LA 70122 (Daughter) Lois Vance 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State 4/8/2011 Metairie, LA Providence Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Sign nure of F meral Service Lice ee ²² Name and Address of Facility Heritage Funeral Directors, Inc. 4101 St. Claude Ave., New Orleans, LA 70117 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Onset and Death Immediate Cause (Final disease or condition Physician/ Medical resulting in death) Due to (or as a consequer Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events law requires that the death certificate be executed Due to (or as a consequence of): resulting in death) Last Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 Yes 2 No Pregnant at time of death g 🗌 Unknown cate has been signed by page 2 should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 2 3 Probably 4 Unknown Completed RENAL FAILURS 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h completed filled in by the funeral director, page 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA မ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation Accident 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 1 Gertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 2011 MAAMW, MI 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHAHID SHAMIN, MD. WASHINGON HOSP, TAKOMA PACK MD-20912 WASHINGON ADVENTIST

Registrar

31. Date filed (Month, Day, Year) PR 0 6 2011 32. Registrar's Signeture

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. nt's Name (First, Middle, Last, 2. Date of Death 3. Time of Death Physician/ 8:32 A M Medical Examiner nber) 8. Date of Birth (Month, Day, 02/11 If Under 24 Hrs. Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1**X** M 2 □ F **Director** 212-78-0176 50 /1961 Marvland Usual Residence of Decedent Show 10a. State 10d. Inside City Limits ral", or items 23a or 28a-f shore Examiner must be notified at 10b. County 10c. City, Town or Location with the Maryland Director PG Upper Marlboro 1**X** Yes 2 □ No MD 10e. Street and Number 10g. Citizen of What Country? Funeral 20772 USA 16601 Village Drive Page 1 and 2 should be filed within 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces' Black, White, etc. Completed by 1 Never Married 2 Married 1 ☐ Yes 2 🙀 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. Specify: Black "natural", 3 Widowed XXDivorced Year or Dates Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mential Hygiene. Important: If item 27 is marked other than any injury or other traumatic event, the Me once. Elementary/Seconday (0-12) College (1-4 or 5+) 12th Installer Private Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ျဉ Mary Elizabeth Hamilton Lawrence Benjamin Ford, 19a. Informant's Name/Relationship (Type, Print) 16601 Village Drive; Upper Marlboro, Alvin E. Ford, Jr - Son 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🔀 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Resurrection 4/11/2011 Clinton, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facilitreeman Funeral Services 4594 Beech Road; Temple Hills, MD 20748 23a. Par 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock or heart failure. List only one cause on each line.
Immediate Cause (Final Approximate Interval Between Onset and Death Physician disease or condition Medical resulting in death) Due to (or a sconsequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impury that initiated events Due to (or as a consequence of) Exami burial-tran and Due to (or as a consequence of): resulting in death) Last ate has been signed by the attending physician page 2 should be detached for use as the burial Physician/Medical the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

The Funeral Director: After this certificate has been signed by the attending physician mapleted filled in by the funeral director, page 2 should be detached for use as the burnapleted filled in by the funeral director, page 2 should be detached for use as the burnapleted. P.O. Box 68760 IF FEMALE yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death
Pregnant at time of death 3 Ectopic pregnancy
5 Other (specify) in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year g 🗌 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? \$ Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed 2 🗌 No 1 Tes To Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural (Month, Day, Year) 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 3 ☐ Suiciae 4 ☐ Homicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exempler: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause 29a. Certifier 2 Medical Exem er: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated se Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b Signature and title of c 29d. Date signed (Month, Day, Year) who completed cause of death (Item 23a) (Type, Print) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 21CHARD A Month 11:15 p M 2011 Medical 4a. Facility Name (if not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death FOCE SAMARITAN HOSPIAN BALTMORE BACTIMORE CITY 9. Birthplace (State or Foreign Country) 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye Sept. 21 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 🛛 M 2 🗆 F Days Hours Director 88 187-03-8197 Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene. 27 is marked other than "natural", or Items 23a or 28a-f show traumatic event, the Medical Examiner must be notified at. 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits Director Baltimore 1 Yes 2 No Maryland Baltimore County 10e. Street and Number 10f. Zip Code 10a. Citizen of What Country? Funeral 1807 Wentworth Rd. 21234 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 Never Married 2 Married Yes 2 ☐ No Yes, Give è Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X XNo Specify. SpecifyWhite Completed 3x Widowed 4 ☐ Divorced Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Federal Government College (1-4 or 5+) Elementary/Seconday (0-12) Dept. of Defense 12 vrs 4 vrs Legal Advisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Edmond Flinn Agnes McFadden 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health ar Important: If item 27 is any injury or other trau once. 3 Bridle Valley Rd. Glen Arm, Md. 21057 Diana E. Darin (Daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ★ Burial 2 Cremation 3 Removal from State Parkwood Cemetery 4-8-2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Lassahn Funeral Home 21. Signature of Funeral Service Ligensee 7401 Belair Rd. Baltimore. 23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician, METASTATIC COLON eANCER FARS Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live Birth 2 Fetal death 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ____ in the past 12 months?
1 Yes 2 No Year Month Pregnant at time of death Day After this certificate has been signed by the a funeral director, page 2 should be detached f Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of death? performed? Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completed filled in by the funeral director; I 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 🗌 Yes 2 No ဂ္ 1 Mainpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28b. Time of Certificate: 28a. Date of injury 28c. Injury at work? 28d. Describe how injury occurred (Month, Day, Year) 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Investigation 6 Could not be Accident 3 ☐ Suicide 4 ☐ Homicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier 7/4 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certific 29c. License number 29d. Date signed (Month, Day, Year) APRIL 3 2011 00059190 2+1 who completed cause of death (Item 23a) (Type, Print) BONNE 5601 LOCH RAVEM BLUD 21239 BALTIMORE

Registrar
DHMH 17 Rev 7/2009

State

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 12:20PM Edmonds Ford 201 Jane Howard **April** Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Harford 42 Graceford Drive Aberdeen If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign Social Security Number 8. Date of Birth Age (In yrs. last birthday) **Funeral** Days 1 M 2 X F Months (Month, Day, 11/08) Virginia **Director** 227-20-3917 85 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits death with the Maryland other traumatic event, the Medical Examiner must be notified at **Funeral Director** 1 X Yes 2 No Harford MD Aberdeen 5 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? "natural", or items 23a 21001 U.S.A. 42 Graceford Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Black, White, etc. δ Q 1 Never Married 2 Married permit. Page 1 and 2 should be filed within 72 hours after. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White Completed 3 Widowed 4 Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. I other than " Elementary/Seconday (0-12) College (1-4 or 5+) Education Teacher Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည Catherine Elizabeth Scott Edward Edmonds Downing 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Jane Ford / Daughter 418 Halsey Road, Annapolis, MD 21401 20a. Method of Disposition Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If it any injury or o ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 X Donation 5 ☐ Other (Specify) 04/05/2011 Anatomy Gifts Registry Hanover, Maryland 21. Signature of Funeral Service Licer 22. Name and Address of Facility Anatomy Gifts Registry 7522 Connelley Dr., Ste. P, Hanover, MD 21076 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequente Examiner Securitally list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) the Hospital or Attending Physician: The law requires that the death certificate be executed by the attending physiclan and tached for use as the burial-tran resulting in death) Last Due to (or as a consequence of): Be Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☑ No Pregnant at time of death Other (specify) 9 Unknown 9 Unknown cate has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 2 🗌 No 3 Probably 24b. Were autopsy findings available prior to completion of cause of 24a, Was an autopsy certificate 2 No 1 Yes 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner's Hospital: ပ္ 1 🗌 Yes 2 1 No 1 Inpatient 2 ER/Outpatient 3 DOA After this 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred atural 5 Pending injury work? Accident Investigation within 24 hours after death

To the Funeral Director:
completed filled in by the 3 ☐ Suicide 4 ☐ Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 3 🗌 29b. Signature and title of certifie 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause death (Item 23a) (Type, Print)

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ April 1:15p 2011 Myrtle Alberta Funk Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death Harford 5 Southworth Court BelAir 5. Social Security Numbe 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min Maryland 1 M 2 X F Months Days Hours 0270571931 Director 213-28-3825 80 Usual Residence of Decedent 23a or 28a-f show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Examiner must be notified at Director 1 ☐ Yes 2 🛣 No Harford Maryland Street 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21154 USA 1130 Poplar Grove Road or items 72 hours after death Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian. Armed Forces Black, White, etc. 1 Never Married 2 Married Completed by 1 ☐ Yes 2 🗷 No If Yes, Give Baltimore, Maryland 21215-0036 Specify: white 1 ☐ Yes 2X No Specify. "natural", 3 XWidowed 4 ☐ Divorced Year or Dates the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than ' Elementary/Seconday (0-12) College (1-4 or 5+) transportation supervisor Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Myrtle Haslach Henry M. Cullum 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 458 New Bridge Road, Rising Sun, MD 21911 Stephen W. Funk (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State any injury or 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Conowingo Church Cemt. 4/5/2011 Conowino, Maryland 4 Donation 5 Other (Specify) 21. Signature of Funeral Service L Maryland 21001 Aberdeen, 23a. Part 1, Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each Immediate Cause (Final Priysician disease or condition Medical resulting in death) Due to (or as a consequence of): Examiner RARS Sequentially list conditions, Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): attending physician and for use as the burial-transit ems Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a quince of): Physician/Medical Box 68760 IF FEMALE 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months
1 Yes 2 No
9 Unknown Month Pregnant at time of death signed by the a d be detached f P.O. Part II. Other, significant conditions continuing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Records, Completed 2 No 3 Probably 4 Unknown page 2 should 24b. Were autopsy findings available prior to completion of cause of death? has autopsy performed certificate 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, of Vital Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 1 No Other: 4 Nursing Home 5 Residence 6 X Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ၉ 27. Manner at leath 28a. Date of injury Certificate: 28b. Time of 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) Natural Accident 5 \square Pending work Division 1 Yes 2 No Investigation 3 Suicide 4 Homicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 🗹 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. the only one 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) (Item 23a) (Type, Print)

DHMH 17 Rev 7/2009

State Registrar 31. Date tiled (Month, Day, Year)
APR 0 6 2011

32. Registrar's Signature

MD21014

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Reg. No. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month 4/3/2011 3:00 A M Ronald Charles Gwyn Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 1441 Streaker Rd. Sykesville Carrol1 Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Days 1 XM 2 F Months Hours (Month, Day, Year) 7/18/1942 Director 199-32-4044 68 Usual Residence of Decedent , or items 23a or 28a-f shov 10b. County 10a. State filed within 72 hours after death with the Maryland other traumatic event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No MD Carrol1 Sykesville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? by Funeral 1441 Streaker Rd. 21784 USA 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Armed Forces? Black, White, etc. 1 Never Married 2 Married Maryland 21215-0036 If Yes, Give Year or Dates 1 Yes 2XX No Specify: "natural", Completed 3 Divorced 4 Divorced Specify: White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) Director of HCFA Federal Government Be permit. Page 1 and 2 should be filed. Department of Health and Mental Hy Important: If item 27 is marked othary injury or other frame. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ٩ Leslie R. Gwyn Dorothy E. Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Janet Gwyn/Wife 1441 Streaker Rd., Sykesville, MD 21784 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 🛮 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 Denation 5 Other (Specify) Pleasant Ridge Cem. 4/7/2011 Woodbine, MD 21. Signat Funeral Service License 22 Name and Address of Facility Burrier-Queen Funeral Home & Crematory, P.A. Old Liberty Rd., Winfield, MD 21784 enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician/ ulmonaru Throsis Medical Due_to (or as a consequence of) Examiner ulmona Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Examiner Due to (or as a consequence of). IA a use as the burial-transit ate has been signed by the attending physician and page 2 should be detached for use as the burial-tran that initiated events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be exec Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Dav 4 ☐ Pregnant at time of death 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ FIPE IDM Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available 24a. Was an autopsy performed? prior to completion of cause of death? certificate 1 Yes 2 No 1 Yes 2 No funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 2 No Hospital Other: မ 1 Inpatient 2 ER/Outpatient 3 IDOA 4 Nursing Home Residence 6 Other (Specify) After this 27. Manner of Death 1 🔏 Natural 28a. Date of injury 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred (Month, Day, Year) 5 Pending injury work? 1 ☐ Yes 2 ☐ No Accident Investigation Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined within 24 hours a To the Funeral C Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 3 🗆 Certifying Nurse Practioner. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 111 5 Md H62176 Donna 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ammana 20 isbon Center Dr Wood bine 708 Md 21791 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State

Registrar

APR 06

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

1 tem 26 per fh 9914 4-6-11 vt
State of Maryland / Department of Health and Mental Hygiene
State of Maryland / Department of Death

1 - State amend items 17,18 per fh g914 (4-8-11) vt
Reg. No. 2. Date of Death dent's Name (First, Middle, Last) Month APRIL Physician/ 03 6:45 PM 2011 Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Examiner BALTIMORE BALTIMORE ARDEN COURTS If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 6. Sex Social Security Number **Funeral** Min. Hours 1 - M 2 X F Months Days 05/16/1914 DC Yrs. 96 Director 216-10-7117 Usual Residence of Decedent 10d. Inside City Limits 28a-f show 10c. City, Town or Location 10a, State 10h County must be notified at Director 1 🗌 Yes 2 🔯 No REISTERSTOWN BALTIMORE MD 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number ō by Funeral 239 USA 21136 115 TEAPOT COURT 13. Was Decedent of Hispanic Origin? (Specity Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give 14. Race - American Indian, 11, Marital Status the Medical Examiner Black, White, etc. 1 Never Married 2 Married ō Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: WHITE "natural", 3 😾 Widowed 4 🗆 Divorced Completed Year or Dates 16a. Decedent's Usual Occupation 16b. Kind of Business Industry 15. Decedent's Education (Give kind of work done during most of working (Specify only highest grade completed) life. DO NOT use retired) al Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) OWN HOME HOMEMAKER 12 Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) th and Mental H

77 is marked of

traumatic ever .. Page 1 and 2 should be fill trment of Health and Mental tant: If item 27 is marked or ဂ Eva Frieman Morris Goodman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 115 TEAPOT COURT, REISTERSTOWN, MD DONNA BELL/NIECE 20c. Location - City or Town, State 20b. Place of Disposition (Name of 20a. Method of Disposition OHR KNESSETH ISRAEL ANSHE SFARD CEM. permit. Page 1
Department of
Important: If it
any injury or o 1 X Burial 2 Cremation 3 Removal from State 04/05/2011 BALTIMORE, MD 4 ☐ Donation 5 ☐ Other (Specify) SOL LEVINSON & BROS., INC. Signature of Funeral Service Like 22. Name and Address of Facility 8900 REISTERSTOWN ROAD, PIKESVILLE, MD 21208 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed Cause (Disease or iinjury the burial-transi that initiated events Due to (or as a consequence of): resulting in death) Last Completed by Physician/Medical Box 68760 phy IF FFMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant Live Birth 2 La recanada

Pregnant at time of death Live Birth 2 Fetal death 3 Ectopic pregnancy Year in the past 12 months?
1 Yes 2 No 1 Yes 2 9 Unknown signed by the a d be detached f 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Division of Vital Records, 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificate has b director, page 2 s performe 1 ☐ Yes 2 ☐ No Yes 2 ATN 26. Place of Death (Check only one) 25. Was case referred to medical 8 Assisted Living examiner? Hospital: Other: 2 No 4 Nursing Home Statesidence 6 K Other (Specify) 1 Tes Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director; After thi completed filled in by the funeral Date of injury (Month, Day, Year) 28b. Time of 28d. Describe how injury occurred 27, Manney of Death 28c. Injury at work? 1 ☐ Yes 2 ☐ No 1 Natural 5 Pending Investigation Accident 6 ☐ Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and itle of certile b of death (Item 23a) (Type, Name and address of person who completed 31. Date filed (Month, Day, State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 3. Time of Death 2. Date of Death Deegdent's Name (First, Middle, Last) Physician/ Month. 201 0221 M ACHEL Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) **Examiner** Anne Arundel Linthicum Chesapeake Hospice House If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Hours (Month, Day, Y Sept. 21 Days Min. Country) 1 \square M 2 1928 MD Director 82 Yrs 217-24-6870 Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at anone. 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Directo 1 Tes 2 No Anne Arundel Pasadena Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral USA 21122 8140 Hog Neck Road Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black, White, etc. þ 1 Never Married 2 Married Yes : 2X No Baltimore, Maryland 21215-0036 Black 1 ☐ Yes 2 ☒ No 3 X Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4 or 5+) Elementary/Seconday (0-12) Household 10 Homemaker Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) မ Hudson Cora Llovd Henson 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8356 Catherine Avenue, Pasadena, MD 21122 Myrtle Henson (sister) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 1 X Burial 2 Cremation 3 Removal from State April 09 Zion Church Cem. Pasadena, Maryland Mt. 4 Donation 5 Other (Specify) 2011 Stallings Funeral Home, P.A. 22. Name and Address of Facility Signature of Funeral Servi 3111 Mountain Road, Pasadena, MD 21122 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest on each line. 23a, Part 1. Enter the disease, or complication shock, or heart failure. List only one caus Approximate Interval Betweer each WWATAS Immediate Cause (Final disease or condition resulting in death) Physician/ Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or linjury Examine Due to for as a consequence on the Hospital or Attending Physician: The law requires that the death certificate be executed attending physician and for use as the burial-transi that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy Day in the past 12 months? Month Year 5 Other (specify) Pregnant at time of death signed by the aid be detached for 9 Unknown g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown should 24b. Were autopsy findings available 24a Was an prior to completion of cause of death? autopsy within 24 hours after death.

To the Funeral Director: After this certificate has completed filled in by the funeral director, page 2 s performed? 2 🗆 No Yes Yes 2 No 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other: 4 Nursing Home 5 Residence 6 Hospital: 2 No 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA မ Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: injury 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide
Homicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) . Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be determined Medical Dertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check 3 Certifying Nurse Practionar: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29d. Date signed (Month, Day, Year) 29c. License number signature and title of certific who completed cause of death (Item 23a) (Type, Print) me and address of person Date filed (Month, Day, Year) 32. Registrar's Signature State 5 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death I. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month LEONARD GERARD HAMBERRY, M.D. 8:50 AM Apri1 Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death STELLA MARIS Timonium Baltimore County 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year Mar 133 6. Sex **Funeral** 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign 1 😾 M 2 🗆 F Months 93 Director MARYLAND 215-01-4033 Usual Residence of Deceden or 28a-f show notified at with the Maryland 10b. County 10c. City, Town or Location Funeral Director N/A 1 X Yes 2 ☐ No Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ıral", or items 23a o Examiner must be 119 Churchwardens Road USA 21212 12. Was Decedent Ever in U.S.
Armed Forces?

1 ☒ Yes 2 ☐ No Ⅷ If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married þ 3altimore, Maryland 21215-0036 1 ☐ Yes 2 🕅 No Specify. "natural" Completed Year or Dates White 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) I Hygiene. Elementary/Seconday (0-12) College (1-4 or 5+) General Surgeon/Physician Medicine Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ <u>John T. Hamberry</u> Adelaide 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Page 1 and 2 sh Department of Health an Important: If item 27 is any injury or other trau once, Elizabeth S. Hamberry (Daughter) 559 Valley View Road, Towson, Maryland 21286 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 1

☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Holy Redeemer Cemetery 4/8/2011 Baltimore, Maryland 21. Signatur A Funer of ervir Access www. Name and Address of Eacility LITCHELL-WIEDEFELD FUNERAL HOME, 500 York Road, Baltimore, Maryl Martin D. Lawson Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Interval Between Immediate Cause (Final Onset and Death Physician/ disease or condition resulting in death) Medical **Examiner** RNA A y uentially list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical 68760 yes, outcome of pregnancy
Live Birth 2 Fetal death 23b. Was decedent pregnant Box 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 Yes 2 No the Hospital or Attending Physician: The law requires that the death Month Pregnant at time of death 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, 2 No Completed 1 Tyes 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? LEONARD HAMBERRY certificate has autopsy perform 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? ပ 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Nursing Home 5 Residence 6 Other (Specify) Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation 6 Could not be within 24 hours are.

To the Funeral Director: Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JUSTINE PREIS, CRNP 2300 DULANEY VALLEY ROAD TIMONIUM, MD31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2011 Registrar

DHMH 17 Rev 7/2009

4,

APRIL

Please Type or Print in Black Indelible Ink Ensure All Copies Are Legible.
State of Maryland / Department of Health and Mental Hygien For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ HAN Month FUNSOOK Year 0118 M 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** umbia County HOSPITAL Howard 0 8. Date of Birth 2/3/1932 9. Birthplace (State or Foreign If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) Social Security Number **Funeral** 1 □ M 2 🗓 F Months Days Hours Mir 9 Prea Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event. 10b County 10d. Inside City Limits 10a. State 10c. City, Town or Location Director EllicoTT 1 🗆 Yes 2 💢 No Howari 10e. Street and Numbe 10g. Citizen of What Country? Funeral Korea 21043 Manahan 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: ASIAN Specify: 3 ₩ Widowed 4 □ Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. PO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) DOMESTIC nousewi Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဨ UNK 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Manahan Dr , KY UNCH Ellicon MD daughter 20a. Method of Disposition
1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State -2011 Hanover, remotory 4 ☐ Donation 5 ☐ Other (Specify) E UNeral 22. Name and Address of Facility HOME 21. Signature of Funeral Servi Howell CVA 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition resulting in death) theroscleratic Cardiovascular Ph sician/ disense Medical Due to (or as a consequence of Examiner Sequentially list conditions, if any leading to in receiving cause. Enter Underlying Examiner Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be executed the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical P.O. Box 68760 IF FEMALE: ves, outcome of pregnancy

Live Birth 2 Fetal death 3 Ectopic pregnancy
Pregnant at time of death 5 Other (specify) 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?

1 Yes 2 No Month Year Day 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 2 🗌 No 1 🗌 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? 2 - No Other: မ 1 Inpatient 2 I ER/Outpatient 3 IDOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Certificate: 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No Accident
Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier st D 8870189 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Cedar Lane Columbia MA Esteban Schabelman MD 5755 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 6 APR Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygien 2 Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month of Physician/ Day 0744 tooper dwar Medical 4a. Facility Name (if not institution, give street and number, **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 3attimore lemorio nior Social Security Number Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. 213-07-830 1 M 2 🗆 Months Davs Hours Country) **Director** Usual Residence of Decedent iral", or items 23a or 28a-f show Examiner must be notified at 10b. County 10d. Inside City Limits should be filed within 72 hours after death with the Maryland 10c. City, Town or Location Director 1 ¥Yes 2 ☐ No ti More 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21223 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S 14. Race - American Indian, Armed Forces or Black, White, etc. þ 1 Never Married 2 Married Yes 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: "natural", Completed 3 Widowed 4 Divorced Year or Dates other traumatic event, the Medical 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) permit. Page 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) OVKer Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) ervolre 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State cemetery, crematory or other place, 1 Burial 2 Cremation 3 Removal from State Arbutus Baltimore 4 Donation 5 Other (Specify Funeral Service 21. Signatur 22. Name and Address of Facility House MU 2120 Batto. Heig 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician/ disease or condition Medical resulting in death) s a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Examine Physician: The law requires that the death certificate be executed burial-transi Cause (Disease or iinjury that initiated events and Due to (or as a consequence of): resulting in death) Last physician Physician/Medical Box 68760 the attending IF FEMALE: for use 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No page 2 should be detached 9 Unknown 9 Unknown Records, P.O. signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🗹 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an has autopsy performed' death? After this certificate ☐ Yes 2 ☐ No Yes 2 No 25. Was case referred to medical examiner? Division of Vital funeral director, Be 26. Place of Death (Check only one) Hospital 2 No Other: ျ 1 Yes 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 27. Mann of Death . Date of injury (Month, Day, Year) 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred Hospital or Attending 1 Natural injury work? 1 ☐ Yes 2 ☐ No 5 Pending Accident Investigation after death the 6 Could not be Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide completed filled in by determined 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.
Certifying Nurse Practioner of the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check within 2 only one 29b. Signature title of certifie 29d. Date signed (Month, Day, Year) 6 201 on who completed cause of death (Item 23a) (Type, Print) BACTIMORE EIMAY N 32. Registrar's Signature APR 06 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ 0.2 Day Month 04 2011 10:00 AMM Dorothy Mae Houtz Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** 4c. County of Death Baltimore <u>Brightview Assisted Living</u> Baltimore 9. Birthplace (State or Foreign Country)
Pennsylvania 1 Year If Under 24 Hrs. 8. Date of Birth **Funeral** 7. Age (In yrs, last birthday) Days Hours 1 🗆 M 2 🕱 F (Month, Day, Year) 06/11/1919 Director 217-24-9335 91 Usual Residence of Decedent 28a-f shov 10a. State 10b. County ed other than "natural", or items 23a or 28a-f sho event, the Medical Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits within 72 hours after death with the Maryland Director 1 Yes 2 No MD Baltimore Perry Hall 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 21128 U.S.A. 9501 Kingscroft Terrace - Apt. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Completed by 1 Never Married 2 X Married Baltimore, Maryland 21215-0036 should be filed within 72 hours after and Mental Hygiene.
is marked other than "natural", 1 ☐ Yes 2 💢 No Specify: Specify: 3 Widowed 4 Divorced White 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaking Own Home 12 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Ethel Keim Russel Camp 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21128 Page 1 and 2 shment of Health a tant: If item 27 is 9501 Kingscroft Terrace - Apt.L - Perry Hall Delbert C. Houtz (husband) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Page 1 Department of Important: If it any injury or o 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 04/05/2011 Upper Falls, Maryland Stonature of Funeral Service Licensee 22. Name and Address of Facility E. F. Lassahn Funeral Home, P.A. Belair Road - Kingsville, Maryland 21087 11750 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final Physician/ disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) attending physician and for use as the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year Pregnant at time of death signed by the a d be detached for 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed: certificate 1 Yes **Division of Vital** To the Hospital or Attending Physician: funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be Other: 4 Nursing Home 5 Residence 2 No ပ 1 Inpatient 2 ER/Outpatient 3 DOA Other (Specify) after death.

Director: After this 28a. Date of injury (Month, Day, Year) Certificate: 27. Manner of Death 28b, Time of 28c. Injury at work? Natural 5 Pending 1 Tes 2 🗌 No Accident Investigation completed filled in by the Suicide Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined within 24 hours a Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check 3 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature and title of certifier 12 and address of person who completed cause of death (them 23a) (Type, Print) My 21042 DANI 0 her 31. Date filed (Month, 32. Registrar's Signature State 6

DHMH 17 Rev 7/2009

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene for State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ 4:29P GUS HOWELL 2011 MARCH Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE TOWSON GILCHRIST HOSPICE If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In vrs. last birthday) 8. Date of Birth **Funeral** 1 X M 2 🗆 F Months Hours Min (Month, Day, Yea Oct. 7 NC NC Yrs Ĭ924 Director 239-26-2766 86 Usual Residence of Decedent 28a-f shov 10b. County 10a. State 10d. Inside City Limits notified at 10c. City, Town or Location Director Baltimore County Baltimore 1 Yes 2 No Maryland| 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Page 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or any injury or other traumatic event, the Medical Examiner must be a one. Funeral 21234 USA 3130 East Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces Black, White, etc. þ 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 Specify: White If Yes, Give WW 11 1 ☐ Yes 2 X No Specify: ¾ Widowed 4 ☐ Divorced Completed 16b. Kind of Business Industry Decedent's Education 16a. Decedent's Usual Occupation (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) Bethlehem Steel Electrical Repairman 5 yrs. Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Ruth Owens Thomas Franklin Howell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) G. Rodney Howell (Son) 3130 East Avenue Baltimore, Md. 21234 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Holly Hill M. G. 4~2~2011 Baltimore, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
Lassahn Funeral Home 7401 Belair Rd. Lassahn Baltimore. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ MACH disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of) Exami physician and the burial-transit Due to (or as a consequence of): resulting in death) Last Physician/Medical To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physici completed filled in by the funeral director, page 2 should be detached for use as the bu Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Day Year Month Pregnant at time of death 2 🗌 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part 23e. Did tobacco use contribute to the cause of death? þ 2 No 3 □ Probably 4 □ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perforr death? Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospital: Other: 4 - Nursing Home 5 - Residence 6 MOther (Specify VC) Pt (2 No 1 Inpatient 2 ER/Outpatient 3 DOA မြ 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at 28d. Describe how injury occurred Certificate: 1 Natural
2 Accident
3 Suicide 5 \square Pending injury, Fall while ambulahn MMCH 8 2011 1 ☐ Yes 2 🔀 No Investigation A 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 - Homicide determined City or Town, State) ZOOE E-LOPPA RD, PHRICUILLEMD parking lot Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 3 [(Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated only one) and title of certifier 29b. Signatu 29d. Date signed (Month, Day, Year) 58303 2011 and address of person who completed cause of death (Item 23a) (Type, Print) 6701 N. ChrysT towson M AARON 31. Date filed (Month, Day 32. Registrar's Signature State 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Year **Physician** Hendricks 2011 nita /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Greater Battimore Medical Center TOWSON Baltamore 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year, 5. Social Security Number 6. Sex **Funeral** Min. 1 □ M 2 💢 F Days Hours 213.52.3838 03 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County 28a-f show ä 1Yes 2 □ No Baltimore MD d 2 should be filed within 72 hours after death with the Man th and Mental Hygiene. ?? Is marked other than "natural", or items 23a or 28a-f sh traumatic event, the Medical Examiner must be notified Director 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) . Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 Married Specify: Black 1 ☐ Yes 2 X No Specify 3altimore, Maryland 21215-0036 þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Baltimore City Elementary/Secondary (0-12) College (1-4or 5+) Social Worker 12th grade 2 years 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert Ruffin Elaine Bower ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) George C. Hendricks Benkert Avenue Baltimore MD Husband of Health item 27 I other 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Important: If iter
any injury or oth 1 Burial 2 □Cremation 3 □Removal from State 4 □Donation 5 □Other (Specify) 2011 Dwings Mills, MD Garrison 22. Name and Address of Facility Vaughon C. Greene Fundral Services 21. Signature of Funeral Service Licensee Landailstain MD 21133 8 Road 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heaf failule. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (* ual disease or condition resulting in death) day Physician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner the Hospital or Attending Physician; The law requires that the death certificate be executed use as the burial-trar Due to (or as a consequence of): Division or Vital Records, P.O. Box 68760, attending properties for use as IF FEMALE: 23c. If yes, outcome pf pregnancy 1□Live birth 2 □ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 X No 4□Pregnant at time of death 5 Other (specify) been signed by the a should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Be Completed by 2 No 3 Probably 4 Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 No 24a. Was an certificate has by inector, page 2 s autopsy performed? 1□ Yes 2 X No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2**X** No 2 KER/Outpatient 3 DOA 1 ☐ Yes 1 Inpatient Medical Certification: To funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 X Natural 2 ☐ Accident 5 ☐ Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death

To the Funeral Director;
completely filled in by the 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier (Check only one) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier cause of death (Item 23/) (Type, Print) Bellona Lane MD 21204 State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Physician/ 6:20 p 2011 Diane Hild. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Carroll Brinton Woods Nursing & Rehab. Sykesville Social Security Number Birthplace (State or Foreign Country)
 MD . If Under 1 Year If Under 8. Date of Birth 7. Age (In vrs. last birthdav) Funeral 1272871934 1 M 2 K Months Hours 215-30-4976 76 Director Usual Residence of Decedent permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State Director Carroll Woodbine 1 Yes 2 No MD 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 21797 USA Funeral 5715 Manor Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give 1 Never Married 2 Married þ Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ₩ Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Housewife 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Daniel Smith Evelyn Hitchock 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 810 Dixon Ave. Sykesville, Md. 21784. Raymond Hild (Son) 20a, Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State ☐ Burial 2 Cremation 3 ☐ Removal from State All County Cremation 04/08/2011 Sykesville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility HAIGHT FUNERAL HOME & CHAPEL, PA 21. Signature of Funeral Service Licensee PO Box 195 Sykesville, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest. Approximate Interval Between shock, or heart failure. List only one cause on each line Soset and Death Immediate Cause (Final disease or condition Pnysician/ -- Medical resulting in death) Due to (or as a nsequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury that initiated events Due to (or as a consequence of): Exami burial-tran Due to (or as a consequence of) resulting in death) Last attending physician for use as the buria Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the a 1 Yes 2 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by 1 Yes 2 No 3 Probably 4 Unknown Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed?/ Yes 2 ☑ No To the Hospital or Attending Physician: The I within 24 hours after death.

To the Funeral Director: After this certificate h 1 ☐ Yes 2 ☐ No 25. Was case referred to medical examiner?

1 Yes 2 No 26. Place of Death (Check only one) funeral director, Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA ပ 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural work? 5 Pending 2 Accident
3 Suicide
4 Homicide Investigation completed filled in by the 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined cal 29a. Certifier 🗗 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner. The best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. Signature and title of gertifier 29d. Date signes (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type Print) Ve JEMP

State Registrar

DHMH 17 Rev 7/2009

32. Registrar's Signature

21136

dy

filed (Month, Day, Year)

11-02555	Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.							
imothy Gene Ham	y in the state of	10978						
Physician/ Medical Examine	Reg. No. 1. Decedent's Name (First, Middle, Last) Timothy Gene Hamm Reg. No. 2. Date of Death Month Day Year	3. Time of Death 1351 hrs						
medical Examine	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death 4c. County of Death							
	7951 Gough Street Dundalk Baltimore Co	unty						
Funeral Director	5. Social Security Number 218-82-1400 1X M 2 F 49 Yrs. Months Days Hours Min. 6. Sex 1/1 Min. 1/2 Min.							
ryland a-f show any f once. ctor	Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location Baltimore	10d. Inside City Limits 1 Xres 2 No						
the Maryland s or 28a-f sh etified at once	10e. Street and Number 7951 Gough Street 21224 10g. Citizen of What Cou							
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 33s or 28s-f sho traumatic event, the Medical Examiner must be notified at once. To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married 2 No Nover Married 2 Nover Marrie	rican Indian, Black,						
urs afte tural"; miner	or Dates:							
5-0036 ed within 72 hours tygiene. other than "natu the Medical Exam Completed	Elementary/Secondary (0-12) College (1-4 or 5+) 12 during most of working life. DO NOT use retired) Truck Driver Trans	portation						
21215-0036 Juld be filed within 7 Mental Hygiene. marked other than cervent, the Medica FO Be Complé	17. Father's Name (First, Middle, Last) William Bassler 18.Mother's Name (First, Middle, Maiden Surname) Stella Hamm							
ore, MD 2121; get 1 and 2 should be fil of Health and Mental Is if item 27 is marked ther traumatic event, TO Be	19a. Informant's Name/Relationship (Type, Print) Stella M. Shorter / Mother 106 West Huron Ct., North East,	e, Zip Code) MD 21901						
# # # # # # # # # # # # # # # # # # #	20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify: 20b. Place of Disposition (Name of cemetery, part of the place) Final Journey Crem. 4/8/2011 Woodbine							
Baltimo permit. Page Department o Important:	21. Signature of Funeral Service Licensed Oro a Mars a 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 2	1203						
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.	Approximate Interval Between Onset and Death						
Examiner	Immediate Cause (Final disease or condition resulting in death) a Gunshot Wound of Head Due to (or as a consequence of):	Deati						
_	Sequentially list conditions, b							
ted Insit E	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated c.							
recuted t and transit	events resulting in death) Last Due to (or as a consequence of):							
ਹ ਸ਼ਿਸ਼ ਂ	UNPENDED AMENDED							
ion of Vital Records, P.O. Box 68760, tending Physician: The law requires that the death certificate be extean. The law requires that the attending physician tor: After this certificate has been signed by the attending physician the funeral director, page 2 should be detached for use as the burial attion: To Be Completed by Physician/Medic	IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of deliver	y Day Year						
Box e death the atte ed for u	1 Yes 2 No 9 Unknown 9 Unknown							
s, P.O. irres that the signed by de detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to 1 Yes 2 V No 3 Pro	bably 4 Unknown						
Division of Vital Records, P.O. Into rattending Physician: The law requires that the safter death. In Director: After this certificate has been signed by led in by the funeral director, page 2 should be detact satisfication: To Be Completed by Prification: To Be		utopsy findings available completion of cause of es 2 No						
Vital Recystchm: The list certificate by director, page	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Others Nursing Home 5 Residence 6 Others Nursing Home							
n of Viiing Physt ing Physt After this funeral dir	27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred	r: Scene						
ion trending teath. A tor: A true fundation ation	1 Natural 5 Pending Pending Investigation Apr 3, 2011 FOUND: 1 Yes 2 No Subject shot self							
	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 4 Homicide 1996. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 7951 Gough Street, Dundalk, MD 29a. Certifier 4 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State) 7951 Gough Street, Dundalk, MD	ural Route Number, City						
the Ho hin 24 h the Fu npletely	(Check only 1 Certifying Physician: 10 the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause(s) and manner as stated as the time, date and place, and due to the cause (s) and the caus							
To with To com	and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mo	nth, Day, Year)						
	O.C.M.E. April 4, 2011							
1	30. Name and address of person who completed cause of death (Item 23a) Victor Weedn MD JDAssistant Medical Examiner111 Penn Street, Baltimore, MD 21201							
State								
Registrar	MER U CUIT KERWAN PO. MATTER							

Registrar

DHMH 17 Rev 1/2001

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible? State of Maryland / Department of Health and Mental Hygiene

		For State		Certific	ate of l	Death				g. No.	
Physician ledical Examine	ı/ li er	. Decedent's Name (First, Middle,Last	Dorothy	Ann		ead		A	Date of Death Month April 2, 201	Day Year 11	1950 1118
	4	a. Facility Name (if not institution, given 3121 Wallford Drive Apt E	street and number)			. City, Town, oi Dundalk				4c. County of Baltimore	e County
Funeral Director		5. Social Security Number 218-74-1047 6. Sex 1. Age (In yrs. last birthday) 45 yrs. If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthple 1. Age (In yrs. last birthday) 45 yrs. Months Days Hours Min. 04/15/1965 Country 1.									
Aaryland 28a-f show any 1 at once.	1	Isual Residence of Decedent 0a. State 10b. County MD Balt	imore	c. City, Town		Du	ndalk				10d. Inside City Limits 1 X Yes 2 No
th the Maryland 23a or 28a-f sho notified at once		Oe. Street and Number 3121 Wallford	Drive Ap	t. E		10f. Zip Code 2	1222		10	g. Citizen of Wh	
r death wi			12. Was Decedent Eve Armed Forces? 1 Yes 2 X	. No	If Yes	Decedent of Hi , specify Cuba 'es 2 X No	n, Mexican, specify:	Puerto Ric	can, etc.)	White Specify:W	hite
5-0036 led within 72 hours afte rlygiene. other than "natural", the Medical Examiner	Completed	15. Decedent's Education (Specify or Elementary/Secondary (0-12) 1 0	College (1-4 or 5+)	ted) 16a.		Usual Occupa t of working life H		use retired		16b. Kind of Bu	Home
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical		7. Father's Name (First, Middle, Last) Douglas Cornw		L			El	lizak	oeth	laiden Surname)	
nore, MD 21214 gges 1 and 2 should be fil fit of Health and Mental F fit If item 27 is marked other treaumatic event,		9a. Informant's Name/Relationship (T William Head	ype, Print) / Husband	1 1	3121	Wallf	ord D)rive	e, Apt	E.E, Du	n, State, Zip Code) andalk, MD
Baltimore, ME permit Pages 1 and 2 s Department of Health as Important: If item 27 injury or other traum	1	Oa. Method of Disposition Burial 2 XCremation 3 Donation 5 Other Specify.		Fina	aI Jo	urney	Crem.	4/8/		Woodbi	
	1	21. Signature of Funeral Service Licen	ic liais	death Dor	22. Na	Mary PO Bo	Land Sx 14	Crem 13,	nation Balti	Servi	Ces MD 21203
Physician Medical Examiner	1	failure. List only one cause on ea mmediate Cause (Final disease a.		e Int							Between Onset and Death
		Sequentially list conditions, b. fany, leading to immediate cause. Enter Underlying Cause Unisease or injury that initiated	Due to (or as a consequ	ence of):							
, # Del _	_	events resulting in death) Last d.	Due to (or as a consequ		20 5	015.5	. 10 1				
be ex bician virial	Medica	X UNPENDED				,g915 5)-1Z-1	1 Sm		1	
	Cian/	F FEMALE: 3b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 V Unknown	23c. If yes, outcome of 1 Live birth 4 Pregnant at tim 9 Unknown	5 - 3 4 -	2 Feta	death 3	Ectopic	pregnancy	y 	23d. Date of Month	Day Year
res that the designed by the leetached leetach	호 도	Part II. Other significant conditions		ut not resulti	ng in the un	derlying cause	given in Pa	irt I.			bute to the cause of death? Probably 4 Unknown
cords,	Completed								24a. Was a autop perfor	sy p m <u>ed</u> ? c	Were autopsy findings available prior to completion of cause of leath? Yes 2 No
tal Recient The certificate ector, page	ပ္ပို	25. Was case referred to medical				26.Plac	ce of Death ((Check only			<u> </u>
Vita hysicia this cel	Ö	examiner? 1 ✓ Yes 2 No	lospital: 1 Inpatient	2 ER/0	Outpatient	3 DOA	Other ₄	Nursing H	lome 5	Residence 6	Other: Scene
ing Physicia Jing Physicia After this cer funeral direct		27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day, Year)	28b	. Time of Inj	· _ ·	ury at Work	- 1	3d. Describe h Unkn o	now injury occurr	ed
isiol Atten er death rector:	Cati	2 Accident Investigati	28e Place of Injury		d 6:0 farm, street	O blu			Sf. Location (S	Street and Numb	er or Rural Route Number, City
E 6 5	Certification	4 Homicide determine	d (Specify) Re	esiden	_				Apt.E	<u>Dunda1k</u>	
To the Hospital yithin 24 hours To the Funcral completely filler	<u>id</u>	(Check only 1 Certifying Physic one) 2 Medical Examine	ian: To the best of my ki	nowledge, de ation and/or	eath occurre investigation	ed at the time, on, in my opinion	on, death oc	curred at the	ne time, date	e(s) and manner and place, and d	lue to the cause(s)
T P S S S S S S S S S S S S S S S S S S	ĕ :	29b. Signature and title of certifier	and manner stated.				nse number				ed (Month, Day, Year)
N. Brog	-	Manyerie 100 30. Name and address of person who	completed cause of dear	th (Item 23a)			:.M.E.			April 3, 20	
Oxpu	-	Margarita Korell MD. As	ssistant Medical Ex	aminar		nn Street, I	Baltimore	, MD 21	201		
Sta Registr	te	31. Date filed (Mostle RV, Vea 6 20	32 Registrar's	Signature	grav						

			For Stata Registrar	State of Mary	land / Depa		Health and M	tental Hygi	_	10980	
1		Œ.	1. Decedent's Name (First, Middle, La					Date of Death Month	Day Year	3. Time of Death	
	Physici		Dorothi	4 L·()	ack	San		April	Day Year 02 2011	12:27 PM	
r	/Medi Examir		4a. Facility Name (If not institution, giv	1			or Location of Death		4c. County of Death		
	LAGITIII		Chesapeake Hospic			Т	inthicum		Anne Ar	undel	
	Funcial	4	5. Social Security Number 6. S		yrs. last birthday)			8. Date of Birth			
-K	Funeral Director			□ M 2 ☑ F	86 Yrs.	Months Days		(Month, Day, June 02	1924 Cou	place (State or Foreign ntry) KY	
	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural", or Items 23s or 28s-f show aumatic event, It is Modical Exenditational by notified at	or	10a. State 10b. County Maryland Anne A		City, Town or Lo	ocation	Pasadena			10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	Ne N	Director	2	I direct		101 71 0 1		10	g. Citizen of What Cou	010.2	
	Vith t	Dir	10e. Street and Number			10f. Zip Code		10		ritiy r	
	a 23a	Funeral	88 Marydale Road				21122		USA		
	er de	rue	11. Marital Status	12. Was Decedent Ever Armed Forces?	in U.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Origin? (Sp. ban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White,		
ð	afte or l	Y F	1 Never Married 2 Married	1 ☐ Yes 2 ☑ No If Yes, Give		1 ☐ Yes 2 ☒ No	o Specify:		Specify: W	hite	
ž	ours	d by	3 ☑ Widowed 4 □ Divorced	Year or Dates:	Sign						
ה ה	72 h natu	ete	15. Decedent's E (Specify only highest gra	ducation	16a. Dece	dent's Usual Occi	upation e during most of work	ina 1	6b. Kind of Business/Ir	ndustry	
7	EPin Ipin	de	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retir	red)				
7	gien gien	Completed	6			Homema	ker		Househo	ld	
פ	oth oth	Be (17. Father's Name (First, Middle, Last,)			18. Mother's Name	e (First, Middle, M	aiden Sumame)		
<u> </u>	should be nd Mental markad c	70 E	Robert Jenki:	ns			Dolly	Curry			
Maryiand 21215-0036	ges 1 end 2 should it of Health and Men it if item 27 is marks or other traumatic	_	19a. Informant's Name/Relationship (Type, Print)	19b. Maili	ng Address (Stree	et and Number or Run	al Route Number,	City or Town, State, Zi	p Code)	
Ĕ	ith all		Nelda L. Scardina	(daughter) 98	Marydale	Road, Pas	N enober	n 21122		
σ	1 end Health am 27 ther tr	8 3	20a. Method of Disposition		b. Place of Dispo	-			Oc. Location - City or T	own, State	
Baltimore,	Pages nent of I int: If Its iry or o		1 ⊠Burial 2 ☐ Cremation 3 ☐	Removal from State	cemetery, cre	matory or other p	17011	1 06	•		
	permit. Page Department (Important: If any Injury or once.		4 Donation 5 Other (Specif	//	Glen Hav	en Cemet	ery 2	011	len Burnie	, maryiano	
<u></u>	Depart Depart Import any In		21. Signature of Funeral Sorvice (ICe)	nsee	2	2. Name and Add	, ,		Funeral H		
n	89 E # 9		Jan 27	5%		3111 M	lountain ko	oad, Pasa	đena, MD 2	1122	
	Physician /Medical Examiner e prival-fransit	il Examiner	23a. Parl . Enter the disease, or o me shock, or heart faill be. List only Immediate Cause (Final disease or condition resulting in death) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	b. Due to (or as a cor	nseque ce of):	I be	eme	Tia		Interval Batween Onset and Death 2 2 3 4 5 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
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Vital Records, F	quires thet n signed build be det	þ	Part II. Other significant conditions of	contributing to death but no	t resulting in the u	anderlying cause g	given in Part I.		23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🚧 nknown		
္ပ	w require been si should t	Completed						24a. Was an	24b. Were aut	opsy findings available	
9	: The law cate has t	ם						autopsy	prior to co	ompletion of cause of	
		ပိ ့							No 1 ☐ Yes	2 💢 0	
	nysician: Th nis certificate director, pag	Be	25. Was case referred to medical examiner?				26. Place of Deat	h Check only one	/		
0	nysir Dis c	၉	1 ☐ Yes 2 No	Hospital: 1 Inpatient	2 ER/Outpatie	nt 3 DOA	ther: 4 🗌 Nursing Ho	me 5 Resider	nce 6 Other (Spec	M HOSPIC	
0	ding Ph h. After th funeral		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time of fnjury	of 28c. Inj	ury at	28d. Describe how	w injury occurred	House	
0	ttendin death. ctor: Af y the fur	atic	1 Accident 5 Pending investigation		,		☐Yes 2☐No				
DIVISION	n or Attending Physician: after death. Director: After this certific: d in by the funeral director,	Certification:	3 Suicide 6 Could not be determined			reet, factory, office	9	28f. Location (Str. City or Town,	eet and Number or Rui State)	ral Route Number,	
	To the Hospital or Att within 24 hours after d To the Funeral Direct completely filled in by	edical C	29a. Certifier 1 Certifying Pt (Check only one) 2 Medical Example 1	nysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, deat mination and/or in	th occurred at the evestigation, in my	time, date and place, opinion, death occur	and due to the ca red at the time, da	use(s) and manner as te and place, and due	stated. to the cause(s)	
	of the composite of the	Me	29b. Signature and title of certifier			29c. Lice	nse number	29	d. Date signed (Month	, Day, Year)	
						77	ACC A	19 1	100145	7 - 11	
			20 Name and address of	nomploted access of the co	(ltom 00-) T	Peint)	50000	1	141,11	4 5011	
			30. Name and address of person who	completed cause of death	(item 23a) (Type,		amade	V Min	C MEN A	1220	
1		3	550SE	cuchie	1419	Mway	1340	- KWV	MUS	1325	
	Sta Regist	- 2	31. Date filed (Month, Day, Year)	32. Registrar's S	gratus	•		,			

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State of Maryland / Department of Health and Mental Hygiene

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UNK UNK		St 1- For State Registrar	ate of Mar	yland / Dep <i>Ce</i>	artment of		d Mental H		2011 a. No.	19981
Physicia Medical Examin	Physician/ edical Examiner 1. Decedent's Name (First, Middle, Last) Devel A Jones							2. Date of Death	Day Year	3. Time of Death 1850 hrs
		4a. Facility Name (if not institutio University Hospital	n, give street and	ĥ	4c. County of Death	12				
Funeral		Social Security Number	6. Sex	7. Age (In yrs.	last birthday)	Baltimore If Under 1 Year	If Under 24Hrs	s. 8. Date of Birth	(MM/DD/YYYY) 9. Bir	
Director	Director 218-08-7934 1 № 2□F						Hours Mir	June	23, 1985 Co	untry) MD
#ny	F	Usual Residence of Decedent 10a. State 10b. County		10c. City	y. Town or Locati	on				10d. Inside City Limits
E		mi) Ra	Hims	70	MICHAE	95 r	n:11.	S		1 Lyes 2 No
Aarylar 28a-f 1	Director	10e. Street and Number		0 1	7 4	10f. Zip Code		_	g. Citizen of What Cour	ntry?
th the h		72 Lower	-	Ct		2	1117		USA	
r death with the Maryland or items 23a or 28a-f show must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Ma	rried Arme	Decedent Ever in U		s Decedent of Hisp es, specify Cuban,			14. Race - Ameri White, etc.	can Indian, Black,
after de	회	3 Widowed 4 Div	orced If Yes, Give		1	Yes 2 No	specify:		Specify: B	lack
hours hours Exami	eted t	15. Decedent's Education (Spec				t's Usual Occupationst of working life.			16b. Kind of Business/I	ndustry
thin 72 te. than tedical	흺	Elementary/Secondary (0-12)	Colleg	ge (1-4 or 5+)		echn	nician	x l	Com	cast
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f shu matic event, the Medical Examiner must be notified at once	ΟĮ.	17. Father's Name (First, Middle,	Last)	T	.!			e (First, Middle, Ma	F - 2 3 3	
21215 Ould be file Mental H marked (c. event, ii)	To Be	19a. Informant's Name/Relations	sip (Type, Print)	Jones	19b. Mailing	Address (Street	and Number or	ne V	er, City or Town, State	
b, MD 21215-0036 and 2 should be filed within 72 hours after leath and Mental Hygiene, tem 27 is marked other than "natural", transmatic event, the Medical Examiner transmatic event, the Medical Examiner.	-	Patricia K	1 . 1	ond	3811	Penh	urst 1	tue, E	Batto M	D 21215
Baltimore, MD permit. Pages 1 and 2 shc Department of Health and Important: If item 27 is injury or other traumatinjury	\mathbb{I}	20a. Method of Disposition 1 Cremation	3 Remova	20b. al from State	Place of Disposi crematory or oth	tion (Name of cem er place)	netery,	Date	20c. Location - City or	200
timo E. Page Iment crant:		4 Donation 5 Other Sp	egffy:	11/	ing .	tark	4	17/2011	Baltin	rore, MD
Baltil permit. Departm Importa	1	21. Side ture of Funeral Service	censee	1111	122. N	ame and Address	of Facility	evell	Funera	al Harris
Physician	1	23a. Part I. Enter the disease, or failure. List only one cause		at caused the death	n. Do not enter th	e mode of dying, s	such as cardiac o	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	-	Immediate Cause (Final disease or condition resulting in death)	a. Multiple	Gunshot Wou						Death
	-	Sequentially list conditions,	b	as a consequence of	or):					
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cuted ind transit	Examiner	(Disease or injury that initiated events resulting in death) Last		as a consequence of	of):					
and and	g G	UNPENDED	d AMENDE	ED .						
		IF FEMALE: 3b. Was decedent pregnant in th		es, outcome of preg	gnancy				23d. Date of delivery	
Box 6876 e death certificate the attending phy ed for use as the be	cian	past 12 months?	1	ve birth egnant at time of d	noth -	al death 3 _ er (Specify)	Ectopic pregna	ancy	Month D	yay Year
BOY	Physician/Me	1 Yes 2 No 9 Unk	19 0	nknown						
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ords, F w requires s been sign should be			.					24a. Was an	24b. Were au	topsy findings available
Records The law requi	Completed							autopsy perform	ed? death?	ompletion of cause of
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death. al Director: After this certificate has been signed by the funeral director, page 2 should be detacted by the funeral director.	ည္ကို- ရွိ	25. Was case referred to medical					of Death (Check			3 2 140
Division of Vital ppital or Attending Physician: ours after death. For all Director: After this certifi filled in by the funeral director.	인	examiner? 1 Yes 2 No	Hospital: 1	Inpatient 2				ng Home 5 R		
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Division tal or Atten us after death al Director: led in by the	<u>∓g</u>	= -	tigation 28e. P	Place of Injury - At h	ome, farm, stree	t, factory, office bu	uilding, etc.		eet and Number or Ru	ral Route Number, City
Divisior Hospital or Attend 24 hours after death Funeral Director tely filled in by the	Certification:	4 V Homicide deter	anternal land	on street				or Town, Sta 1200 Wincheste	te) er Street, Baltimore,	Md.
	ਲ ।		niner:On the bas	sis of examination a					s) and manner as state nd place, and due to the	
T. S.	ğ	29b. Signature and title of certifie	and manne	er stated.		29c. License	number	:	29d. Date signed (Mor	oth, Day, Year)
		Cardl H	all	der		O.C.M	1.E.		April 1, 2011	
١		 Name and address of person Carol Allan, MD Ass 		cause of death (Iten		treet, Baltimoi	re, MD 2120	1		
Sta	_	31. Date filed (Month, Day, Year)		. Registrar's Signat						
Registra		APR 0.6 2011	OCME	1 B. A	acker					
DHMH 17 Rev 1/200	71				ORIGINAL					

11-02522 Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Charles Johnson State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No. Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day April 2, 2011 Charles Medical Examiner Antwione Johnson 0141 hrs 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Johns Hopkins Hospital **Baltimore** 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday) If Under 1 Year If Under 24Hrs Hours Foreign Months Min Director 1986 215.13.2685 1 M 2 F Usual Residence of Decedent 10a State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No Baltimore MD or 28a-f show Windsor Pages I and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.
ant: If item 27 is marked other than "natural", or items 23a or 28a-f shoor or other traumatic event, the Medical Examiner must be notified at once. Director 10e Street and Number 10g. Citizen of What Country? Court Garden Leu Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Never Married 2 Married 1 Yes Black If Yes, Give Year or Dates: 1 Yes 2 No specify: 3 Widowed 4 Divorced Specify: 2 16a, Decedent's Usual Occupation (Give kind of work done 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 permit. Pages 1 and 2 should be filed within 7. Clerk Computer Company Hh Ovade 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) SVIVIA Johnson 19a. Informant's Name/Relationship (Type, Print) (Grand Father (Street and Number or Rural Route Number, City or Town, State, Zip Code) harles Ernest Kew Garden Court Windsor Mill, MD 21244 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State crematory or other place) 1 Burial 2 Cremation 3 Baltimbre, MD Department o Mt. Carmel Cametery 4 Donation 5 Other Specify: laugin Greene neva Services 21, Signature of Funeral Service Licenses 22. Name and Address of Faulity Randall Staun MD 21133 8+28 Libertu road he disease, or complications that caused the death. Do not enter the mode of dying, such as bordiac or respiratory arrest, shock, or hear Approximate Interval **Physician** List only one cause on each line Between Onset and /Medical Death a Stab and Cutting Wounds of Left Thigh ≟xamineı or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions. if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Exami (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical 16b per fh g914 4-6-11 vt UNPENDED **AMENDED** Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 2 Fetal death 3 Ectopic pregnancy Month Year Dav past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 V No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of performed' death? Yes 2 No 1 🗸 Yes 2 No 25 Was case referred to medical 26. Place of Death (Check only one) Be examiner? Other Nursing Home 5 Residence 6 Other 1 🗸 Yes 28a. Date of Injury (Month, Day,Year) Apr 2, 2011 27. Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Subject assaulted 1 Natural 0104 hrs 5 Pending 1 Yes 2 V No 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f, Location (Street and Number or Rural Route Number, City 6 Could not be Suicide or Town, State) 316 Guilford Avenue, Baltimore, Md 4 V Homicide determined (Specify) Bar/tavern Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number April 2, 2011 OL V O.C.M.E 30. Name and address of person who completed cause of death (Item 23a) Carol Allan, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

DHMH 17 Rev 1/2001 **OCME 2006**

State Registrar

ORIGINAL

OCME

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygienes Certificate of Death . Decedent's Name (First, Middle, Last) 2. Date of Death Time of Death Physician/ Month .0004 Medical 4a. Facility Name (if not institution, give street and number own, or Location of Death **Examiner** 4c. County of Death If Under 1 Year 8. Date of Birtl 9. Birthplace (State or Foreign Funeral Months 1 🗆 M 2 🗸 F Director item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Examiner must be notified at Page 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene. ant: If item 27 is marked other than "natural", or items 23a or 28a-1 sho 10a. State 10c. City, Town or Location 10d. Inside City Limits Funeral Director 1 Yes 2 No 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? sehi 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black. White, etc. 1 L Yes 2 No If Yes, Give 1 Never Married 2 Married δ Maryland 21215-0036 1 🗆 Yes 2 📉 Specify 3 Widowed 4 ☐ Divorced Completed Year or Dates. 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working 16b. Kind of Business Industry (Specify only highest grade completed) fe. DO NOT use retired) ay (0, 12) College (1-4 or 5+) To Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle Informant's Name/Relationship (Type, Frin 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) ueline Baltimore, 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Important: If any injury or ò 4 ☐ Donation 5 ☐ Other (Specify) Signatur of Funeral Ser vice Licensee M01553 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on auch line. Interval Between Onset and Death Immediate Cause (Final +nysician/ disease or condition resulting in death) Medical Due to or as a consequence of) **Examiner** Sequentially list conditions, Examiner Due to (or as a consequence of) if any, leading to immediate cause. Eller Underlying Cause (Disease or linjury Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 2 should be detached for use as the burial-transit that initiated events Due to (or as a consequence of) resulting in death) Last Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner? Hospita Other: 2 No 1 Tes မှ 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify 28a. Date of injury (Month, Day, Year) Certificate: Manner of Death 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No Investigation Accident Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29c. License number 29b. Signature 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 7/2009

Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 325 **Physician** 201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner Baltimore City** The Johns Hopkins Hospital 9. Birthplace (State or Foreign Country) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5. Social Security Number Age (In yrs. last birthday) **Funeral** Days Hours Min a Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a. State 10b. County 23a or 28a-f show 1 Yes 2 □ No or other traumatic event, the Medical Examiner must be notified **Funeral Director** timore 10g. Citizen of What Country? Street and Number Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. "natural", or items Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 1 Yes No If Yes, Give Year or Dates: Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes No Specify 4 Divorced þ 3 - Widowed Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) nentary/Secondary (0-12) and Mental Hygiene. is marked other than College (1-4 or 5+) 17. Father's Name (First, Middle, Last) Be • تع ر ည 19b. Mailing Address (Street and Number or Rural Route Number, City or permit. Pages 1 and 2:9 Department of Health at Important: If item 27 is any Injury or other trauonce. 20b. Place of Disposition (Name) 20a. Method of Disposition Burial 2 Cremation 3 Removal from State Donation 5 Other (Specify) of Funeral Service Licer 21. Signatura Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a co ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 \square Live birth 2 \square Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 - Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2X No 3 Probably 4 Unknown 1 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an 1 Yes 2 No 1 Yes after death.

Director: After this certificate 25. Was case referred to medical 26. Place of Death (Check onl one Be examiner? Other 2 No 1 Inpatient 3 🗌 DOA 4 Nursing Home 5 🗌 Residence 6 Other (Specify) 1 🗌 Yes 2 ER/Outpatient မ 28b. Time of 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending investigation Injury 1 Yes 2 No 3 🗌 Suicide 6 Could not be Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, Cify or Town, State) determined 4 - Homicide 24 hours a Funeral I the Hospital 1 (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (check only one) and manner stated. within 2 To the F 29c. License number 29b. Signature and 000 ocompleted cause of death (Item 23a) (Type, Print) 600 North Wolfe St, Baltimore, MD, 21287 31. Date filed (Month, Day, APR 0 6 201 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene. Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 4 Month 4 Physician/ David Joseph AM 210 201 Medical Facility Name (If not institution, give street and number) Examiner Town, or Location of Death 4c. County of Death redical mu If Under 24 Hrs. 8. Date of Birth
(Month, Day, Year)
5-20-1925 5. Social Security Number 6. Sex 7. Age (In vrs. last birthday) If Under 1 Year 9. Birthplace (State or Foreign **Funeral** 1 □**x**M 2 □ F Hours Min. Country) Director 217-20-0375 85 Usual Residence of Decedent 10b. County 10c. City, Town or Location the Maryland 10d. Inside City Limits Director be notified 28a-f 1 No MD Anne Arundel Glen Burnie 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Country? 23a Funeral and 2 should be filed within 72 hours after death with I Health and Mental Hyglene. Health and Mental Hyglene. The marked other than "natural", or items 23a the 72 is marked other than "natural", or items 23a the traumatic event, the Medical Examiner must b. 107 Hilltop Road 21060 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Bace - American Indian. Black, White, etc. Completed by I 1 Never Married 2 Married 3altimore, Maryland 21215-0036 1 ☐ Yes 2 ☐xNo Specify: Specify: White 3 XWidowed 4 Divorced Year or Dates. WWTT 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Automotive Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ည <u>Frank A. Dobry</u> Olive Corns 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health Important: If item 27 any injury or other tronge. <u> Sharon Barrett - Daughter</u> 9196 Rolling Meadow Run Pasadena, MD 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 ☐ Burial 2 🔀 Cremation 3 ☐ Removal from State 4-6-11 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) Atlantic Crematory Signature of Funeral Service Lidensee 22. Name and Address of Facility Bradley-Ashton Funeral Home ow Spring Road. 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Interval Between Onset and Death Immediate Cause (Final Ph_sician/ neumoni weeks disease or condition Medical resulting in death) Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or impry that initiated events Examine Due to (or as a consequence of): attending physician and for use as the burial-tran Due to (or as a consequence of): resulting in death) Last Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 5 Other (specify) in the past 12 months? Day Pregnant at time of death 2 No After this certificate has been signed by the funeral director, page 2 should be detached Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed Yes 2 2 🗆 No 1 TYes or Attending Physician: ¹ after death. Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ၉ 1 🗌 Yes 2 No 1 Nnpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of injury (Month, Day, Year) To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completed filled in by the funeral 27. Manner of Death 28b. Time of Certificate: 28c. Injury at 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No М Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29b. Signature a 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) UNORY

Registrar DHMH 17 Rev 7/2009

State

31. Date filed (Month, Day, Year)

P.O. Box 68760

Division of Vital

physicien and s the burial-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed ettending for use as as ed by the e within 24 hours efter death.

To the Funeral Director: After the completely filled in by the funeral

Physician

/Medical

Examiner

Funeral

Director

in then "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at

other 7 is marked othe treumatic event,

permit. Pages 1 and 2 should be filt Depertment of Heelth and Mental Hy Important: If Item 27 is marked oth any linjury or other treumatic event 2002.

Physician /Medical Directo

Funeral

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Completed

Be

Examine

Physician/Medical

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Completed

Be

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Certification:

Medical

State Registrar

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

that initiated events resulting in death) Last	C. Due to (or as a conseq	uence of):								
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 4 Pregnant at time of death 5 Other (specify) 9 Unknown									
Part II. Other significant conditions of	-	ulting in the underlyin	g cause given in Part I.	23e. Did tobacc	co use contribute to the cause of death? 2 ☑No 3 ☐ Probably 4 ☐Unknown					
				24a. Was an autopsy performed 1 Yes 2						
25. Was case referred to medical			26, Place of D	eath (Check only one)						
examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify)									
27. Manner of Death 1 Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury occurred						
3 Suicide 6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fac fy)		28f. Location (Street and Number or Rural Route Number, City or Town, State)						
29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of my kno iner: On the basis of examina and manner stated.	owledge, death occur ation and/or investigat	red at the time, date and pla tion, in my opinion, death oc	ice, and due to the cause courred at the time, date	e(s) and manner as stated. and place, and due to the cause(s)					
29b. Signature and title of certifier			29c. License number	29d.	1. Date signed (Month, Day, Year)					
I dually on	m()		D3510	2 A	- April 5, 2011					
30. Name and address of person who could be a second address of person address of pe	and the same of th	n 23a) (Type, Print)	vus Street	Balton	ore MD 2121U					
31. Date filed (Month, Day, Year) APR 0 6 201	32. Registrar's Sign	facel	,							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Physician/ Month 14 (14°) **2**011 Kusterer, Sr. рм 01:30 Edward Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore Stella Maris Timonium If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) **Funeral** Social Security Number 6. Sex 7. Age (In yrs. last birthday) Days Min. 1 X M 2 - F 05/11/1916 217-14-5492 Director 94 Yrs. Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Director 28a-f 1 X Yes 2 No Baltimore MD N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral must be and 2 should be filed within 72 hours after death with Health and Mental Hygiene. Satem 27 is marked other than "natural", or items 23a other traumatic event, the Medical Examiner must b other traumatic event, the Medical Examiner must b U.S.A. 21206 5415 Todd Avenue Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian 11. Marital Status Armed Forces? Black, White, etc Completed by 1 Never Married 2 Married 2 No Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Specify: 3 💢 Widowed 4 🗆 Divorced White Year or Dates. WWII 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Defense Mechanical Engineer 12 6 Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Harrigan Mary Jane Kusterer Lawrence 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5415 Todd Avenue, Baltimore, MD 21206 Department of Health Important: If item 27 any injury or other the once. James Kusterer, Son 20a. Method of Disposition 20b. Place of Disposition (Name of Date 20c. Location - City or Town, State 1 🔀 Burial 2 🗆 Cremation 3 🗆 Removal from State cemetery, crematory or other place) 04/08/2011 Baltimore, Maryland 4 Donation 5 Other (Specify) Gardens Of Faith 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road, Baltimore, MD 21214 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betweer Immediate Cause (Final Onset and Death Plantician/ disease or condition Medical resulting in death) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine or Attending Physician: The law requires that the death certificate be executed after death. Cause (Disease or iinjury that initiated events Due to (or as a consequence of): resulting in death) Last physician a the burial-EDWARD KUSTERER APRIL 4'
Division of Vital Records, P.O. Box 68760' Completed by Physician/Medical attending p for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death
4 Pregnant at time of death
9 Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year cate has been signed by the page 2 should be detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of 24a. Was an autopsy perform death? 1 🗌 Yes 2 🗀 No Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 2 No Other: ္ဝ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Certificate: 28d. Describe how injury occurred 1 Natural 2 Accident 3 Suicide 4 Homicide injury work? 1 ☐ Yes 2 ☐ No 5 Pending М Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town, State) Hospital Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Curifying Numb Practiciner: To the best of my knowledge doubt commed at the time, date and place, and due to the cause(n) and manner as stated. or ly one 29b. Signature and title of 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PALLEY RD TIMONIUM MD 2300 DULAKY JONES CAN 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar DHMH 17 Rev 7/2009

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend #5 State of Maryland/PDepartine Hof Health and Mental Hygiene - State Registrar Certificate of Death 0000 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^D2011 Physician/ April 5. Shelby 5:30a Jean Koch Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City. Town, or Location of Death 4c. County of Death Harford Aberdeen 2132 Perryman Road If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Age (In yrs. last birthday) Days 1 M 2 XF Hours May 28, Year 962 MaryTand Director 220-76-1149 48 Usual Residence of Decedent show permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.

Important: If item 27 is marked other than "natural", or items 23a or 28a-f shown any injury or other traumatic event, the Medical Examiner must be notified at once. 10a. State 10b. County 10c. City, Town or Location Director 1 X Yes 2 No Harford Maryland Aberdeen 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 2132 Perrymand Road 21001 USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, þ 1 Never Married 2XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐XNo Specify: Specify: White Completed 3 Widowed 4 Divorced Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life, DO NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) contractor <u>engineer technician</u> Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Charles Sexton Annie Marie Spurlin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2132 Perryman Rd., Aberdeen, MD 21001 James R. Koch (husband) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harford Memorial Gardens 4/8/2011 Aberdeen, Maryland Signature of Funeral Service 22. Name and Address of Facility Tarring-Cargo Funeral Home, P.A. Aberdeen, Maryland 21001 uster 23a. Part 1. Enter the disease, or complications that careed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between shock, or heart failure. List only one cause on each line Immediate Cause (Final Onset and Death Physician/ lefastati cances disease or condition resulting in death) cononth Medical Due to (or as a consequence of): **Examiner** Secure tight list conditions Examine if any, leading to immediate cause. Enter Underlying Cause (Disease or iinjury Due to (or as a consequence of): the Hospital or Attending Physician: The law requires that the death certificate be executed use as the burial-transi that initiated events resulting in death) Last attending physician and Due to (or as a consequence of) Physician/Medical Division of Vital Records, P.O. Box 68760 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Day Year Pregnant at time of death signed by the aring the best of the second s Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾| Completed 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 1 Yes 2 No 1 Yes 2 No 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🛛 No Certificate: To 1 Inpatient 2 ER/Outpatient 3 DOA Director: After this d in by the funeral di 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1' Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, determined City or Town. State) To the Hospital within 24 hours a To the Funeral Completed filled Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 29b. Signature/and title of certifier 29d. Date signed (Month, Day, Year) Sussalam M.D. D45530 4-5-2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 5-SIVASAIVAM, 602, S Atwood, Belair -MD 21014 Depera. 32. Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3 Time of Death 1. Decedent's Name (First, Middle, Last) KUNKDWSKI **Physician** 18:45 PM VIRGINIA APRI 2011 /Medical 4a. Facility Name (If not institution, give street and number, 4b. City, Town, or Location of Death 4c. County of Death Examiner Johns Hopkins Bayview Medical Center **Baltimore** N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 😿 F 214-22-7673 83 Director 11,1927 Maryland Oct. Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene. Int if Item 27 Is merked other then "naturel", or Items 23a or 28a-f ehow 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Exeminer must be notified at 1 ☐ Yes 2x No Director Baltimore Co. MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip-Code 21224 7707 Eastdale Road United States Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2¥ If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: à 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Department of Health and Mental Hygiene. Importent: If Item 27 Is merked other then "natur any injury or other treumetic event, the Medical E 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Own Home Homemaker 12 Years 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mabel White George Piniecki ည 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 1625 Andylin Way Eldersburg, Maryland Mr. Joseph Kunkowski (Son) 21784 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Date 1

Burial 2

Cremation 3

Removal from State ☐ Donation 5 ☐ Other (Specify) Baltimore, Maryland Faith Cem. 4/9/2011 Signature of Funeral Service Licensee 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** RESPIRATORY F
Due to (or as a consequence of) disease or condition resulting in death) days /Medical **Examiner** MONTHS Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant 1 Live birth 2 Fetal death 4 Pregnant at time of death 3 - Ectopic pregnancy in the past 12 months? Month Day 5 Other (specify) 2 No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 1 TYes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autops, performed? Yes 2 № No 1 ☐ Yes 2 🗌 No or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Inpatient 1 Yes 2 No Other: 2 ER/Outpatient 3 DOA $4 \square$ Nursing Home $5 \square$ Residence $6 \square$ Other (Specify) မ 28c. Injury at Work? 27. Mannes of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Injury 1 Natural 5 Pending investigation 1 🗌 Yes 2 No hours after death. 2 Accident within 24 hours after death To the Funeral Director: 3 Suicide 6 Could not be 28e. Place of injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 ☐ Homicide the Hospital 29a. Certifier Manager in Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal (check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) APRIL RES-000

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DHMH 17 Rev 1/2001

State Registrar

6 2011 Jenus S. factor

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

FERNANDA PORTO CARREIRO MD

31. Date filed (Month, Day, Year)

4940 Eastern Avenue, Baltimore, MD, 21224

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month 400N Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death Examiner IEN NURSING HOME olumbi 4 R 9. Birthplace (State or Foreign Country) KOREI 7. Age (In yrs. last birthday)
Yrs. 8. Date of Birth Month, Day, Year) 924 If Under 1 Year If Under 24 Hrs. **Funeral** Months **Director** Usual Residence of Decedent or 28a-f show 10d. Inside City Limits permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Medical Examiner must be notified at 10a. State 10c. City, Town or Location Director 1 Yes 2 □ No 10g, Citizen of What Country? Funeral 5 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No
If Yes, Give Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No 5 Completed 3 Widowed 4 Divorced Year or Dates. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) eaners Be 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) 2 50014 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of cemetery, crematory or other place)
ARALWT MOMINATION 20a. Method of Disposition 1 ☐ Burlal 2 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) HANOVER ARdIW 21. Signature of Funeral Service Licensee ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final CANCER Phylician ADDER disease or condition resulting in death) Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) signed by the attending physician and deedetached for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregna 5 Other (specify) Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Dav Year Pregnant at time of death 4 ☐ Pregnant 1 ☐ Yes 2 L 9 ☐ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably ♣ ☐ Unknown Be Completed within 24 hours after death.

To the Funeral Director: After this certificate has been Mellitin 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) completed filled in by the funeral director, 2 No ျ 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 28c. Injury at work? Medical Certificate: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No 2 Accident
3 Suicide
4 Homicide Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29a. Certifier (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signature and title of certifier 29d, Date signed (Month, Day, Year) 00053150 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9650 Sentago Rd 2,045 halevnnell 32. Registrar's Signaty State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registrar naa Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ^{Day}2011 Physician/ April William Wayne 1 12:25 A M Kent, Sr. Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Kline Hospice House Mt. Airy Carroll 5. Social Security Number If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 8. Date of Birth **Funeral** Aug. 18, 1**X** M 2 □ F Months Days Hours Min Year) 1949 Virginia 227-70-1808 61 Yrs. Director Usual Residence of Decedent 28a-f show 10b. County 10a, State 10c. City, Town or Location at 10d. Inside City Limits Director must be notified 1 X Yes 2 No Maryland Frederick Frederick 0 10e. Street and Numbe 10f. Zip Code 10g. Citizen of What Country? 23a Funeral 2040 Rosecrans Court 21702 U.S.A. 12. Was Decedent Ever in U.S.

Armed Forces?

1 ⚠ Yes 2 ☐ No 1969

If Yes, Give 1971 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Examiner Black, White, etc. "natural", or þ 1 Never Married 2 X Married within 72 hours after Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify. Specify: Black. Completed 3 Widowed 4 Divorced 1971 Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) and Mental Hygiene. College (1-4 or 5+) Elementary/Seconday (0-12) General Manager MV Transit Company Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Page 1 and 2 should be fili Department of Health and Mental Important: If item 27 is marked of any injury or other traumatic eve 2 William Albert Kent Marjorie Fields 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Nina Renee Walton-Kent (Wife) 2040 Rosecrans Ct., Frederick, MD 21702 20a, Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Garanter or minor of other place)
Veterans State Cemetery 4/6/2011 1 X Burial 2 Cremation 3 Removal from State 4 Donation Other (Specify) Owings Mill, MD 21. Signature of Funeral Service Licenses 22 Name and Address of Facility Fisher-Watkins Funeral Ho 707 Wilson St., Da**nvill**e, 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death shock, or heart failure. List only one cause on each line Immediate Cause (Final disease or condition Physician/ recurrent Medical resulting in death) **Examiner** Months mmunosuppro Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of): physician and the burial-transit Cause (Disease or iinjury that initiated events resulting in death) Last that the death certificate be executed Due to (or as a consequence of): attending physician for use as the buria Physician/Medical Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy
5 Other (specify) in the past 12 months? Month Day Year Pregnant at time of death Yes 2 No ed by the a 9 Unknown 9 Unknown P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. signed by 23e. Did tobacco use contribute to the cause of death? þ Records, 1 Yes 2 No 3 Probably 4 honknown cate has been sig page 2 should b Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No certificate 1 Yes within 24 hours after death.

To the Funeral Director: After this certific completed filled in by the funeral director, Division of Vital Be Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 🖔 Other (Specify) 1 Yes 2X No ပ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 1 🖺 Natural 28a. Date of injury (Month, Day, Year) 28c. Injury at 28b. Time of 28d. Describe how injury occurred Certificate: Hospital or Attending 5 Pending 1 Yes 2 No ☐ Accident Investigation 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide determined Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check 3 🗌 To the I within 2 only one) 29b. Signature and the of certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) OV

Registrar DHMH 17 Rev 7/2009

State

ORIGINAL

32. Registrar's Signature

MI

31. Date filed (Month, Day, Year)

APR 0 6 2011

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death April Day $2011^{\rm Year}$ Charlotte Loring Knauer 3, 5:00 Ам 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Westminster Carroll Carroll Hospital Center 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye 3/5/1936 6. Sex Age (In vrs. last birthday) Birthplace (State or Foreign Country) Year) 1□ м 💥 ғ Months Days Hours Min 75 230-38-4783 WV Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 ☐ Yes 2 X No MD Carroll Westminster 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code United States 3312 Ridge Rd. 21157 12. Was Decedent Ever in U.S. Armed Forces?
1 Yes XX No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 X Never Married 2 ☐ Married If Yes, Give Year or Dates: 1 ☐ Yes 2X No Specify. Specify: White 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16h Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bethelem Steel Ship builder 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Helen Elimore John Marshall 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3312 Ridge Rd. WEstminster, MD 21157 19a. Informant's Name/Relationship (Type. Print) Jinelle Holbrook (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 🛣 Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Carroll Crematory | 4/7/2011 Sykesville, MD 22. Name and Address of Facility 21. Signature Burrier- Queen Funeral Home and Crematory, 1212 W. Old Liberty Rd. Winfield, MD 21784 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Se juentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregrant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death?

Physician /Medical Examiner The law requires that the death certificate be execut

P.O. Box 68760

Division of Vital Records,

Hospital or Attending Physician:

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Physician/Medical

Physician

/Medical

Examiner

Funeral

Director

28a-f shov

Director

Funeral

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Completed

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item 27 is marked other than "natural", or items 23a or 28a-f sho other traumatic event, it a "golical Examinat ninst be notified at

within 72 hours after

12 should be filed within h and Mental Hygiene. 7 Is marked other than

Pages 1 and 2 item 27 Is

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Important: If ite
any injury or ot

Baltimore, Maryland 21215-0036

attending physician and for use as the burial-trar ned by the sigr 1 be s been si should certificate n 24 hours after death.

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bletely filled in by the fu

ed by	DIABETES A		uning in the underlyin	g cause given in Part i.		No 3 Probably 4 4 Unknown	
Completed					24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death? 1 □ Yes 2 ☑ No	
Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
0	1 Yes 2 →No	Hospital: 1 🗍 Inpatient 2 🗍	ER/Outpatient 3	DOA Other: 4 Nursing	Home 5 ☐ Residence 6	3 ☐ Other (Specify)	
ation:	27. Manner of Death 1 ☐ Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury M	28c. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how injury	y occurred	
Certifica	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Special	ome, farm, street, fac fy)	tory, office	28f. Location (Street and Number or Rural Route Number, City or Town, State)		
Medical (29a. Certifier (Check only one) 1 Certifying Physical Exami	sician: To the best of my knowner: On the basis of examination and manner stated.	owledge, death occur ation and/or investigat	red at the time, date and plation, in my opinion, death oc	ce, and due to the cause(s) curred at the time, date and	and manner as stated. place, and due to the cause(s)	
ž	29b. Signature and title of certifier			29c. License number	29d. Date	e signed (Month, Day, Year)	

State Registrar

31. Date filed (Month, Day, Year)

APR 06

completely within 2

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

edistrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Registrar Certificate of Death Reg. No: 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician/ Month Day Year Norma Graves King Medical 4a. Facility Name (if not institution, give street and number) **Examiner** 4b. City, Town, or Location of Death 4c. County of Death 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth Month, Pay, Year Nov 11, 1923 **Funeral** 9. Birthplace (State or Foreign Country Maryland Months Days Hours Min 217-14-2706 87 **Director** Usual Residence of Decedent or 28a-f show notified at 10a. State 10c. City, Town or Location 10d. Inside City Limits Director MD Baltimore 1 🗆 Yes 2 🔀 No Lutherville 10e. Street and Number ŏ 10f. Zip Code 10g. Citizen of What Country? or than "natural", or items 23a or the Medical Examiner must be Funeral 126 Charmuth Road 21093 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S. 14. Race - American Indian, Armed Forces? Black, White, etc. 1 ☐ Never Married 2 🕅 Married þ Maryland 21215-0036 1 ☐ Yes 2 No Specify: If Yes, Give Year or Dates 3 - Widowed 4 - Divorced Completed white Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) of Health and Mental Hygiene. Item 27 is marked other than other traumatic event, the Me Elementary/Seconday (0-12) College (1-4 or 5+) Homemaker Own Home Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) မ Edwin A. Graves Aeonah Burnett 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) it of Health a John B. King, Jr. / husband 126 Charmuth Road; Lutherville, MD 21093 Baltimore, 20a. Method of Disposition

1 ☑ Burial 2 ☐ Clemation 3 ☐ Removal from State

4 ☐ Donation 5 ☐ Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Department of Important: If i any injury or c Dulaney Valley Mem Gardens | 4/8/2011 Timonium, MD 21. Signature of Funeral pervice I 22. Name and Address of Facility 1050 York Road Towson, MD 21204 Ruck Towson Funeral Home, Inc. 23a. Part 1. Enter the disease, or complica s that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate shock, or heart failure. List only on Interval Between
Onset and Death Immediate Cause (Final Ph_sician/ disease or condition resulting in death) Medical Due to (or as a consequence of): Examiner Securativity list of with the Examine if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of): or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Cause (Disease or linjury and that initiated events resulting in death) Last Due to (or as a consequence of) signed by the attending physician Physician/Medical Division of Vital Records, P.O. Box 68760 23b. Was decedent pregnant 23d. Date of delivery in the past 12 months?
1 ☐ Yes 2 🗶 No ò Year Month Day Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by be ABDOMINAL AORTIC ANEURYSM 1 Yes 2 □ No 3 □ Probably 4 □ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a, Was an this certificate has al director, page 2: autopsy performed? Yes 2 No 2 X No 1 Yes 25. Was case referred to medical æ 26. Place of Death (Check only one) examiner? 101. Hospital 2 🔀 No 1 🗌 Yes 1 Inpatient 2 KER/Outpatient 3 I DOA 4 Nursing Home 5 Residence 6 Other (Specify) To the Funeral Director: After th completed filled in by the funeral Certificate: 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at 28d. Describe how injury occurred 1 💢 Natural 5 Pending iniury work?
1 Yes 2 No 2 Accident
3 Suicide Investigation 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined To the Hospital within 24 hours a To the Funeral L the Hospital Medical 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and tit 29c. License number 29d. Date signed (Month, Day, Year) ress of person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) 32. Registrar's Signature State APR 0 6 2011 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Year Physician 1010 AMM Ethel Carolyn Lozzi 05 04 2011 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Baltimore Franklin Square
5. Social Security Number 6. S Rosedale
If Under 1 Year | If Under 24 Hrs. Center Hospita Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday, 8. Date of Birth (Month, Day, Year) **Funeral** Months Days 1 ☐ M 2 ☐ F 14,1935 213-32-6731 July Maryland Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits show 7 is marked other than "natural", or items 23a or 28a-f sho traumatic event, Inc. Medical Evan, invention to mathe 1 ☐Yes 2 XNo Director MD Baltimore Dunda1k 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21222 3407 Wallford Drive Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status should be filed within 72 hours after 1 ∐Yes 2 1 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married 0221, Ethel ore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Maryland State permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'any injury or other traumatic event, the Meonee. Elementary/Secondary (0-12) College (1-4or 5+) Police Medivac 12 Years Secretary 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Ethel Louise Enback Rudolph John Knott ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type. Print) 233 Sandhill Road Baltimore, Maryland 21221 Mrs. Lisa Westerman (Daughter) altimore, 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State Hilltop Service Corp. 4/11/2011 Towson, Maryland 4 ☐ Donation 5 ☐ Other (Specify) f Funeral Service License 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, 23a. Part 1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or flear failure List only one cause on each line.

Immediate Caus 4 Fina disease or condition resulting in death)

a. 7922 Wise Ave. Dundalk, Maryland Approximate Interval Between Onset and Death Physician /Medical Due to (or as a consequence of): Examiner Aspiration Preumonia Sequentially list conditions, if any, leading to infinite data cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to the as a consequence of: Examiner be executed burial-trar Due to (or as a consequence of): Box 68760, physician Physician/Medical Attending Physician: The law requires that the death certificate the attending pl for use as t IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🗷 No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) cate has been signed by the page 2 should be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. \$ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🕱 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy rmeg? 2 X No certificate 1 ☐ Yes 2 X No 1 ☐ Yes funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA After this Certification: To 28a. Date of Injury (Month, Day, Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending To the Hospital or Attendir within 24 hours after death.

To the Funeral Director: At completely filled in by the fu death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifie Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title o D 69540 05 M.D. 2011 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Woods Rd Suite LO4 Parkrille MD 21234 8813 Wal Man 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

minic Gerson Littlejohn Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene UNK UNK 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle,Last) Physician/ Month Day March 24, 2011 1449 hrs Medical Examiner Dominic Gerron Littlejohn 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Northbound Ramp of I-95 at I-295 Oxon Hill If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** DC Hours Months Days Director 09/18/1979 Washington 2 F 31 577-21-7068 Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 1 X Yes 2 No DC Washington death with the Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20019 USA 340 - 35th Street, N.E. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black, 11. Marital Status 12. Was Decedent Ever in U.S. Funeral Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No 1 Yes Specify: Black 1 Yes 2X No specify: hours after 4 Divorced If Yes, Give Year <u>ā</u> 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done Completed during most of working life. DO NOT use retired) Pages 1 and 2 should be filed within 72 h nent of Health and Mental Plygiene, nnt: If item 27 is marked other than "n r other traumatic event, the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 Private Truck Driver GED 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Veda Grayton Elroy Littlejohn 8 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3563 55th Avenue #12; Hyattsville, MD Veda Littlejohn – Mother 20c. Location - City or Town, State 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, Date crematory or other place) 1 Burial 2 Cremation 3 Removal from State Washington Nat'l Cem 4/5/2011 Suitland, MD 4 Donation 5 Other Specify: 22. Name and Process of Fility Funeral Services 21. ignature of Funeral Service Licensee unn notreema 4594 Beech Road; Temple Hills, Maryland 20748 231 Fart I. Enter the discase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one thuse on each line. /Medical Death a Multiple Injuries Immediate Cause (Final disease ≟xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) Examiner if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit Physician/Medical AMENDED 23a, 27, 28a-f, per me g916 6-29-11 sm X UNPENDED Records, P.O. Box 68760, 23d. Date of delivery 23c. If yes, outcome of pregnancy IF FFMALE Was decedent pregnant in the 3 Ectopic pregnancy Day Year 1 Live birth Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a. Was an prior to completion of cause of autopsy . death? performed? Yes 2 No 2 No 1 Yes 26. Place of Death (Check only one) 25. Was case referred to medical Division of Vital 8 Other₄ Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 ✔ Other: Scene 1 🗸 Yes Subject climbed over jersey wall and jumped from highway bridge 27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work? Certification: $\texttt{fd} \, \overset{(\mathsf{Month, Day, Year)}}{3-24-11} \, 1$ Natural fd 2:40 pm 1 Yes 2 X No 5 Pending 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City, or Town, State Ramp North Bound I-95 @ 295 Oxon Hill, Md. 28e. Place of Injury - At home, farm, street, factory, office building, etc 6 Could not be 3 X Suicide Highway Bridge determined (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier OOME March 25, 2011 OCME. Theodor M. They TR.
30. Name and address of person who completed cause death (Item 23) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Theodore M, King, Jr., MD. 32. Registrar's Signature APR 0 6 2011 State arka Registrar

ORIGINAL

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death ρ Physician/ Month Year 23:32 Medical 4a. Facility Name (if not institution, give street and number **Examiner** Town, or Location of Death 4c. County of Death NIA MAMORE n yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign Country) **Funeral** . Age (1 □ M 2 👺 Months Hours Director bouth Korea March Usual Residence of Decedent ortant: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other traumatic event, the Medical Examiner must be notified at permit. Page 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If item 27 is marked other than "natural", or items on any injury or other trainmate. 10b. County Completed by Funeral Director 10c. City, Town or Location 10d. Inside City Limits 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Korea 12. Was Decedent Ever in U.S. . Was Decedent of Hispanic Origin? (Specify Yes or No-11. Marital Status 14. Race - American Indian, Armed Forces?
1 ☐ Yes 2 ☑ No Yes, specify Cuban, Mexican, Puerto Rican, etc. Black, White, etc. 1 Never Married 2 Married If Yes, Give Year or Dates 1 Yes 2 No Specify: 3 ₩idowed 4 Divorced Specify: Sian 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DQ NOT use retired) Elementary/Seconday (0-12) College (1-4 or 5+) Be 17. Father's Name (First, Middle, Last) LLN K 18. Mother's Name (First, Middle, Maiden Surname) 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21102 Collins Vuashinaton Wav Marcheste Yun 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State ☐ Burial 2 Defemation 3 ☐ Removal from cemetery, crematory or other place, 4 Donation D Other (Specify) tanover Signature of all ervice License unura MD 25794 23a. Part 1. Enter the disea shock, or heart failure ations that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death -Physician Medical Examiner umonia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine attending physician and for use as the burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Cause (Disease or linjury that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No 5 Other (specify) Month Day Year Yes _ Unknown Pregnant at time of death signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown page 2 should within 24 hours after death.

To the Funeral Director; After this certificate has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed' 2 🗌 No 1 Yes Yes funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner's 2 No Other: 1 Tes |은 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 Nursing Home 5 Residence 6 Other (Specify) 28a. Date of injury (Month, Day, Year) 27. Manney of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred 1 Natural 5 \square Pending 1 Yes 2 🗌 No Investigation Accident 3 Suicide
4 Homicide 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 3 🗆 Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one 29b. Signature and title 9 4/2/11 MD 30 Name and address of person who completed cause of death (Item 23a) (Type Print)

DR. P. PATE / C/D Many and FEAE E ENCI 31. Date filed (Month, Day, 32. Registrar's Signature State 06 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First_Middle_Last) 2. Date of Death 3. Time of Death Physician/ Month Year EDNA M. LENHART 10 31 AM 04 2011 Medical 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** GOOD SAMARITAN HOSPITAL Baltimore City Baltimore Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** 1 M 2 XF Days Hours February 23 1918 Baftindre, Maryland 93 219 18 7020 **Director** Usual Residence of Decedent 28a-f show 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits or other traumatic event, the Medical Examiner must be notified at Director 1 X Yes 2 No Baltimore Maryland Baltimore City 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō Funeral USA 21218 1614 Roundhill Road should be filed within 72 hours after death 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Armed Forces?

1 Yes 2 No Black, White, etc. þ 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: If Yes, Give Year or Dates White Completed 3[™] Widowed 4 □ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) if Health and Mental Hygiene. Elementary/Seconday (0-12) Housekeeping-Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) 2 Henrietta Frances Rae Charles H Crovo 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1614 Roundhill Road Baltimore, Maryland 21218 Richard David Lenhart 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place)

Metro Crematory Inc April 5 2011 20c. Location - City or Town, State permit. Page 1 Department of Important: If it any injury or o ō 1 Burial 2 Cremation 3 Removal from State Baltimore, Maryland 4 Donation 5 Other (Specify) Signature of Funeral Service Licenses 22. Name and Address of Facility Lassann Funeral Home Inc 7401 Belair Road Baltimore,<u>Maryland 212</u>36 Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. 23a, Part 1. Enter the disease Approximate Interval Between Onset and Death Immediate Cause (Final Physician/ disease or condition Myocardial Infarction Medical resulting in death) Due to (or as a consequence of) **Examiner** artery coronary Sequentially list conditions, cause. Enter Underlying Cause (Disease or linjury that initiated events Examine Due to (or as a nonsequence of). Due to (or as a consequence of): resulting in death) Last Be Completed by Physician/Medical Hospital or Attending Physician: The law requires that the death certificate be Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live Birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 5 Other (specify) ____ in the past 12 months?

1 Yes 2 No
9 Unknown Month Day Year Pregnant at time of death 9 Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ite on chronic renal failure, CHR Afib No 3 ☐ Probably 4 ☐ Unknown 1 Tes 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Pulmonary Embolism, Hypertension autopsy performed Yes 2 🗌 No 1 🗌 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဂ္ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certificate: 27. Manner of Death 28a. Date of injury 28b. Time of 28c. Injury at 28d. Describe how injury occurred Natural (Month, Day, Year) injury 5 Pending work? 1 ☐ Yes 2 ☐ No M 2 Accident
3 Suicide
4 Homicide I Director: And in by the f Investigation 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, within 24 hours after d

To the Funeral Direct
completed filled in by 1 determined Medical Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Certifying Nurse Practioner: To the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. To the ! 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Dav. Year) inoit MD 04/03/2011 RESOU Q 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SURAJ TIME 5601 LOCH RAVEN BLVD BALTIMORE MD 21239 SINA

DHMH 17 Rev 7/2009

State Registrar 31. Date filed (Month, Day, Year)

APR 0 6 2011

32. Registrar Signature

State of Maryland / Department of Health and Mental Hygien Certificate of Death 1. Decedent's Name (First Middle Last) Date of Death Time of Death Physician/ Phil Medical 4a. Facility Name (if not institution, **Examiner** 4c. County of Death 9725 Slalom Run Drive Woodstock Baltimore If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** Min. Months Hours (Month, Day, Director Jamaica Usual Residence of Decedent 10a. State 10b. County Page 1 and 2 should be filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits Director items 23a or 28a-f sl ner must be notified Baltimore Wood Stock 1 ☐ Yes 2 No MD 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? Funeral 75 Slalom 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 0 1 Never Married 2 Married Completed by 1 Yes 2 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced Specify: Black "natural" Year or Dates traumatic event, the Medical 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business Industry (Specify only highest grade completed) d Mental Hygiene. marked other than Elementary/Seconday (0-12) College (1-4 or 5+) Tailor 12th grade Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ပ Harold Lewis Lepecca 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Health a C. Lewis 25 Slalom Kun Drive Woodstack MD 21163 Lola Department of Healt Important: If item 2 any injury or other i 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 Burial 2 Cremation 3 Removal from State Druid Ridge Cemeter 0412 2011 Pikesville 4 ☐ Donation 5 ☐ Other (Specify) 22. None and Address of Facility Vaughn C. Signature of Funeral Service Licensee Greene Funeral SVGS 8 Liberty Roadandallstown MD 21133 23a. Part 1. Enter the tisease, or complications that caused shock, or heart fallure. List only one cause on each line. lisease, or complications that caused the death. Do not enter the mode of dying, such is cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause /Final Physician/ disease or condition resulting in death) Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of) Due to (or as a consequence of) Hospital or Attending Physician: The law requires that the death certificate be IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live Birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 ☐ Yes 2 ☐ No Month Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24a. Was an 24b. Were autopsy findings available autopsy performed prior to completion of cause of death? 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital Other: ျှ 1 Tes 2 X No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 Nursing Home 5 Residence 6 Other (Specify 27. Manner of Death 28a. Date of injury 28b. Time of Certificate: 28d. Describe how injury occurred 28c. Injury at after death. Director: After Natural (Month, Day, Year) work?
1 Yes 5 Pending 2 🗌 No Accident Investigation within 24 hours after dex To the Funeral Director completed filled in by th Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Homicide determined Medical 29a, Certifier 🗫 ertifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. only one) 29b. Signatur ne and address of person who completed cause of death (Item 23a) (Type 6 2011 32. Registr State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ George Leo Logue, Jr. 2011 11:20 AM APRIL Medical 4a. Facility Name (if not institution, give street and number) 4c. County of Death
BALTIMORE 4b. City, Town, or Location of Death **Examiner** CENTER TOWSON SAINT JOSEPH MEDICAL Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** onth, Day, Days Months 1**X**□ M 2 □ F Year 940 Mary land 70 Director 220-36-4272 Nov. Usual Residence of Decedent i Hygiene. I other than 'natural'', or items 23a or 28a-f show vent, the Medical Examiner must be notified at 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits Page 1 and 2 should be filed within 72 hours after death with the Maryland Director 1 ☐ Yes 2 🔀 No Rio Hampshire WV. 10g. Citizen of What Country? USA 10e. Street and Number 10f. Zip Code Funeral 26755 133 Cardinal Drive Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian. 11. Marital Status Armed Forces?
1 ☐ Yes 2X No Black, White, etc. 1 Never Married 2 X Married þ Maryland 21215-0036 1 Yes 2 No Specify. Specify: White If Yes. Give 3 Widowed 4 Divorced Completed Year or Dates 15. Decedent's Education 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business Industry (Specify only highest grade completed) Elementary/Seconday (0-12) College (1-4 or 5+) Education Principal Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) and Mental F 2 Mary Elizabeth Schultz George Leo Logue, Sr. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar Important: If item 27 is any injury or other trau 4300 Conifer Court Glen Arm, MD. 21057 Carrie Wallace/ Daughter Baltimore, 20b. Place of Disposition (Name of 20a. Method of Disposition 20c. Location - City or Town, State Date cemetery, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Timonium, MD. 4-8-11 Dulaney Valley Mem. 4 Donation 5 Other (Specify) 21. Signature of Funeral Sewice Lici nsee 22. Name Ruck Towson Funeral Home, 1050 York Rd. Towson, MD. 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final SEPTIC SHOCK Physician disease or condition Medica resulting in death) Due to (or as a consequence of): **Examiner** CLOSTRIDIUM DIFFICILE COLITIS Sequentially list conditions. cause. Enter Underlying Cause (Disease or iinjury Exami METASTATIC LUNG CANCER burial-transit the Hospital or Attending Physician: The law requires that the death certificate be executed that initiated events Due to (or as a consequence of) resulting in death) Last been signed by the attending physician should be detached for use as the burial Physician/Medical Division of Vital Records, P.O. Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy

1 Live Birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 5 ☐ Other (specify) ___ in the past 12 months? Month Day Year 1 Yes 2 No g Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown Were autopsy findings available prior to completion of cause of 24a. Was an within 24 hours after death.

To the Funeral Director: After this certificate has autopsy perform death? 1 Yes 2 No 1 ☐ Yes 2 🕱 No Be (25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 🗌 Yes 2 🔀 No မှ 1X Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death 28a. Date of injury (Month, Day, Year) 28b. Time of 28c. Injury at Certificate: 28d, Describe how injury occurred X Natural 5 Pending injury 1 Yes 2 No Accident Investigation 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, 4 Homicide determined City or Town, State) Medical 1 🔀 Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated (Check Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 3 only one) 29c. License numbe 29d. Date signed (Month, Day, Year) 29b. Signature and title of certific D0067248 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

State Registrar

31. Date filed (Month, Day, Year).

7601 OSLER DRIVE, TOWSON MARYLAND 21204 GRETCHEN DICKINSON M.D.

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Kathryn Patricia Luster Day 2 Month 3 090500 Medical 4a. Facility Name (if not institution, give street and number) Examiner Town, or Location of Death Baltimore 4c, County of Death Union Memorial Hospital 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2**X** F Months Days 217-66-4107 55 **Director** Yrs. Usual Residence of Decedent 28a-f shov 10a. State 10b. County Examiner must be notified at 10c. City, Town or Location 10d. Inside City Limits Director mD Baltimore 1 X Yes 2 No 10e. Street and Number ò 10f. Zip Code 10g. Citizen of What Count Funeral UŚA 23a 1301 West Madison Avenue Apt. 21217 items 11. Marital Status 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Armed Force Black, White, etc. ö ρ 1x Never Married 2 Married 2 X No Baltimore, Maryland 21215-0036 If Yes, Give Year or Dates 1 ☐ Yes 2 ☑ No Specify: Specify: Black "natural", Completed 3 Divorced 4 Divorced event, the Medical 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business Industry (Give kind of work done during most of working and Mental Hygiene. is marked other than life. DO NOT use retired) Elementary/Seconday (0-12) Page 1 and 2 should be filed within College (1-4 or 5+) Own Home Homemaker Be 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname)

Jean Floravine Luster ပ္ William Charles Connors, Sr. traumatic 19a. Informant's Name/Relationship (Type, Pnint) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) item 27 Barbara Luster Sister 1301 W. Madison Ave, Apt. E, Baltimore, injury or other 20a. Method of Disposition 20b. Place of Disposition (Name of permit. Page 1 a
Department of H
Important: If ite
any injury or ott 20c. Location - City or Town, State Date 1 Burial 2 Cremation 3 Removal from State cemetery, crematory or other place) 4/6/2011 Woodbine, MD 4 ☐ Donation 5 ☐ Other (Specify) Final Journey Crem. Dorota Marshall 22. Name and Address of Facility Maryland Cremation Services PO Box 1413, Baltimore, MD 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final Onset and Death Physician/ Cardropulmorar Medical resulting in death) Due to (or as a consequence of): **Examiner** Cardiac Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Examine Due to (or as a consequence of) Preumonia Cause (Disease or linjury burial-tran that initiated events resulting in death) Last Due to (or as a consequence of): physician the burial Hospital or Attending Physician: The law requires that the death certificate be a 24 hours after death.

Funeral Director: After this certificate has been signed by the attending physicis Physician/Medical Box 68760 for use as 23c. If yes, outcome of pregnancy
1 ☐ Live Birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No 5 Other (specify) Month Day Year the a 9 Unknown 9 Unknown P.0. edetach Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? s been signe should be c Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an cate has b autopsy performed Yes 2 2 🗌 No 1 Yes **Division of Vital** 25. Was case referred to medical funeral director, Be 26. Place of Death (Check only one) examiner? Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) ျှ 1 Yes 1, Inpatient 2 ER/Outpatient 3 DOA 28a. Date of injury (Month, Day, Year) Manner of Death Certificate: 28b. Time of 28c. Injury at work? 28d. Describe how injury occurred Natural 5 Pending 1 Yes 2 🗌 No Accident Investigation completed filled in by the 6 Could not be Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide determined Medical 29a. Certifier Certifying Physician: To the best of my knowledge, death occured at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, geath occurred at the time, date and place, and due to the cause(s) and manner as stated

Certifying Nurse Practioner: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated (Check Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. within 2 To the F only one) 29b. Signature and title of certifier 29c. License number 30. Name and address of perspn who completed cause of death (Item 23a) (Type, Print) V 201 E. University 31. Date filed (Month, 32. State 6 0

Registrar